

**STATE OF INDIANA  
DIVISION OF AGING  
FINAL PROJECT REPORT  
BUILDING A COMMUNITY LIVING PROGRAM FOR THE STATE OF INDIANA**

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## Contents

EXECUTIVE SUMMARY.....	5
INTRODUCTION / HISTORY .....	6
WHY CHANGE NOW .....	11
INTAKE AND TARGETING .....	12
THE PRIORITIZATION TOOL .....	13
TARGETING .....	17
A MORE ROBUST ADRC.....	17
DETERMINATION OF NEED .....	19
CRITICAL VERSUS NON-CRITICAL SERVICES .....	20
PROCESSING NON-CRITICAL NEEDS .....	22
AUTHORIZING SERVICES IN A NEW WAY .....	23
THE ACTION PLAN .....	24
THE ROLE OF THE RESOURCE COUNSELOR.....	25
TRANSITIONING TO A CASE MANAGER .....	29
PERSON CENTERED CARE .....	34
PERSON CENTERED CARE FOR THE RESOURCE COUNSELOR.....	35
CLIENT START-UP PROCESS.....	37
PRE-CONTACT .....	37
INITIAL CONTACT.....	37
UNABLE TO CONTACT.....	37
THE HOME VISIT .....	38
PERSON CENTERED CARE FOR THE ADRC .....	39
ADRC – INDIANA’S SINGLE POINT OF ENTRY SYSTEM.....	40
PERSON CENTERED CARE FOR CASE MANAGEMENT .....	41
GOAL DEVELOPMENT .....	43
What is Person Centered Planning? .....	45
THE ASSESSMENT TOOLS.....	46
Mapping Supports and Relationships.....	46
Individual History and Profile.....	47
Home and Mobility Assessment.....	48
Wellness Assessment .....	48

The Caregiver Assessment .....	49
Establishing Goals.....	49
Using the Assessments to Identify Goals.....	50
Using the Goals to Manage Outcomes .....	50
FOLLOW UP .....	50
WHAT WE LEARNED .....	51
Benchmark Reports .....	51
FACE TO FACE.....	55
CALLER PERCEPTION OF NEED VERSUS ACTUAL NEED.....	56
ELIGIBILITY SCREEN ACCURACY BY PHONE ASSESSMENT VERSUS FACE TO FACE.....	60
THE PRIORITIZATION TOOL .....	62
ANALYSIS OF HIGH RISK FACTORS.....	64
Review of the Prioritization Tool from the LifeTime Resources staff.....	72
ADRC.....	73
Determination of Need.....	73
CRITICAL VERSUS NON-CRITICAL NEED .....	75
Action Plan .....	77
AUTHORIZING SERVICES .....	77
RESOURCE COUNSELING .....	79
Cost Share .....	80
Verifying Resources .....	82
PERSON CENTERED CARE.....	83
REDUCING CASE LOADS .....	85
STAFF SURVEY .....	86
FOLLOW-UP.....	90
HOME CARE MANAGER .....	90
The Waiting List.....	92
THE IMPORTANCE OF COMMUNICATION .....	93
CULTURE CHANGE .....	94
THE CASE MANAGER’S ROLE.....	96
TALKING POINTS.....	97
LEADERSHIP.....	97

COMMUNITY LIVING GRANT FINAL RECOMMENDATIONS .....	99
RECOMMENDATION: MOVE TO A NEED-BASED MODEL .....	99
RECOMMENDATION: CHANGE COST SHARE .....	100
RECOMMENDATION: PROMOTE PERSON CENTERED CARE .....	102
PARTICIPANT DIRECTED CARE .....	103

## EXECUTIVE SUMMARY

The purpose of this grant was to work with two of Indiana's Aging and Disability Resource Centers (ADRC) to ensure that individuals at greatest risk of nursing facility placement and Medicaid spend down receive services and to build the infrastructure necessary to support the growth of person-centered and participant directed supports.

The target population for this effort was older adults and the disabled within the planning and service area of 8 counties in northcentral and southeastern Indiana.

The results of this project resulted in a new method of triaging individuals in need of assistance to remain independent in their homes and communities. This grant provided the opportunity for the area agencies to change the culture of their organization and resulted in a "road map" that could be followed by other organizations in managing the needs of older adults and the disabled.

This project was initiated to develop a system that could be replicated by all sixteen ADRC within Indiana.

The program implications are impressive. Indiana has developed and documented the framework needed to move from eligibility determination to need based care model. Through policy, Indiana would change the way in which it serves the elderly and disabled and address the increased demands on aging services as the population continues to age and the demand for care increases.

As a result of the study, the area agencies on would recommend that Indiana move to a need based care model that incorporates a new method of triaging client care based on an effective determination of need and an implementation of person-centered care.

## INTRODUCTION / HISTORY

This grant was written as a means for Indiana to address the impending wave of older adults who will be knocking on the door of our already taxed systems, looking for desperately needed help to remain independent. This multifaceted approach addresses these issues and through this grant, provides a road map to replicating similar successes.

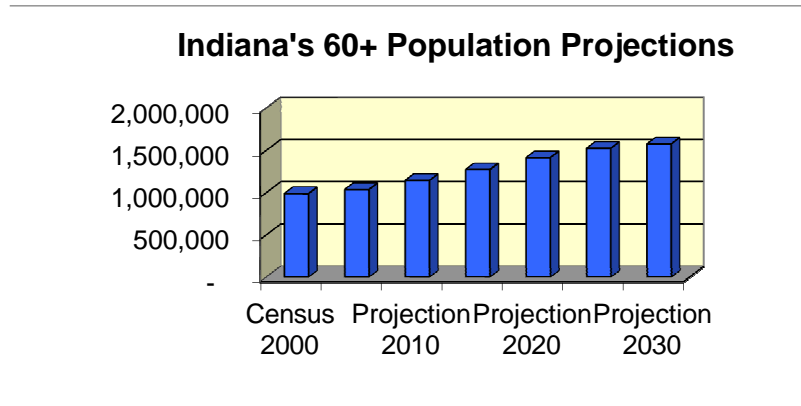


Figure 1: Indiana's 60+ Population Projections

For several years, Area 12 (*LifeTime Resources*) has had no waiting list. *LifeTime Resources* has been operating a new approach which works with families to fully utilize their current resources prior to relying on state and federal funding. It had often been proposed that the success of Area 12 was due to their rural designation and the “neighbors help neighbors” culture that is often credited to rural communities. However, in the model that Area 12 developed, the ADRC identified and assisted those most in need with both formal and informal resources to meet their needs.

Within the scope of this grant, Scripps Gerontology Center of Miami University did a review of the processes used by *LifeTime Resources* (See: Attachment A). The review sought to answer three questions:

1. Could the agency get another ongoing revenue source to support older consumers who are in need of long-term services and supports?

2. How could the agency effectively maximize local funding without becoming overly dependent on it?
3. Were other programs and resources available in the community that the agency was not accessing at the time?

The results of the study indicate that, “the staff of *LifeTime Resources* appears to have embraced both the concept and practice of maximizing individual resources in their work with area families”. The report adds, “As Indiana, and the rest of the nation, continues to age it will face continual pressures to provide long-term services and supports to its citizens. The service model being implemented by *LifeTime Resources* represents an important strategy to maximize individual and community resources and in our view represents an interesting program innovation that should receive continued study.”

*LifeTime Resources* developed a PowerPoint that would illustrate the evolution of the organization as it developed its options counseling program. (See: Attachment B)

Area 2 was one of the leading ADRCs in the state in diverting individuals from a nursing home or bringing an individual home from a nursing home stay. This success was based on providing person centered options counseling to persons in the nursing home, and assisting with the transition to home. This was accomplished in part by integrating the ADRC in the service process with the intent to assist those considering nursing home placement. Area 2 made efforts to break down silos between services, particularly Pre-Admission Screening, Case Management and the ADRC, so as to create a safety net to capture individuals.

Early into the project, it was understood that if an ADRC was to be successful, a culture shift was required. A culture shift may be difficult at a large ADRC, where communication and monitoring of change processes becomes problematic because staff may be geographically and socially isolated from leadership. Area 2 intended to make the approach work to prove that it was

not merely a rural phenomenon but one that any size ADRC could accomplish if they were committed. Area 2 set out to build a road map for making their culture shift successful.

## PROJECT GOALS

The project goals were to 1) establish mechanisms to ensure that individuals at greatest risk of nursing facility (NF) placement and Medicaid spend down receive services and 2) to build the infrastructure necessary to support the growth of person-centered (PC) and participant-directed (PD) supports.

A final activity was to conduct an evaluation of the entire program and establish a unified rollout and sustainability plan. We identified a number of small pilots for individual pieces of the infrastructure that allowed us to improve these tools before they are rolled out statewide.

Our objectives were to:

- Pilot and validate a research-based, objective, and standardized approach to targeting services to individuals most at risk for nursing home placement and spend down.
- Incorporate a person centered approach into operations
- Develop an infrastructure that will provide counseling to accompany the participant directed services offered.

### **GOAL 1: Restructure intake, assessment, and selection of individuals to target individuals at high risk of nursing facility placement and Medicaid spend down;**

*Indiana has implemented a statewide “No Wrong Door” ADRC system through its 16 Area Agencies on Aging network. As a result, the State of Indiana has made tremendous progress in providing non-Medicaid home and community based services while assisting individuals in the Medicaid eligibility application process*

- Develop a standardized approach based upon the Minimum Data Set for Home Care (MDS-HC) that identifies and assigns priority for access to services;
- A new triaging process that applies the high-risk targeting criteria will be added between assessment and options counseling.

### **GOAL 2: Incorporate a Person-Centered Philosophy into all operations;**

*Make revisions to intake, Options Counseling, assessment and Care Coordination, and training materials that incorporate a person-centered philosophy into these key operations.*

- When an individual first requests assistance, the individuals acting as first contact must try to understand the individual’s motivation for seeking support in addition to gathering information that is necessary to determine if a full assessment is merited.



- The second major change is to make the assessment more person-centered. This effort builds off a model developed by Minnesota that involves incorporating a brief person-centered interview to the beginning of the assessment process.
- We will examine the performance requirements and adjust training protocols provided to Care Coordinators to reflect the person-centered philosophy.

**GOAL 3: Build an infrastructure to manage the quality of Participant Directed services;**

*Indiana has developed a participant directed attendant care program that is available under state and federal funding streams. The program allows individuals to manage the quality of services provided by their service providers.*

- Increase the flexibility of Person Directed options;
- Build infrastructure to assist individuals in managing their own supports.
- Develop a participant manual that includes forms, checklists, and other tools that will assist individuals in performing tasks like recruiting, training, managing, and firing workers.
- Develop a program for training Care Coordinators on how to train Participant Directed participants and their representatives to manage their supports. This will include establishing training curricula and providing training on an ongoing basis.
- Develop a mentoring program in which individuals who have been successfully self-directed their care can mentor individuals who are new to the program.

## OVERVIEW OF COMMUNITY LIVING GRANT GOALS



### **PARTICIPANT DIRECTED CARE**

- § Develop manuals for employees,
- § Develop manual to help employers learn to manage their employees
- § Develop a mentoring program
- § Develop policies and procedures as needed
- § Manual for Case Managers to understand their role
- § Develop quality assurance plans

### **REVISED COST SHARE**

- § Implement a new cost share
- § Integrate a lower threshold for assets

### **PERSON CENTERED PLANNING**

- § Integrate into all ADRC functions
- § Development of tools
- § Adjust training protocols

### **PRIORITIZATION TOOL**

- § Identify those at greatest risk of nursing home placement and Medicaid spend down
- § Develop a method for evaluating greatest need

Figure 2: Overview of Community Living Grant Goals

## WHY CHANGE NOW

Meeting the needs of those served or to be served with less personnel and resources is a paramount challenge. Determining how to serve consumers well is key.

A system that is not efficient or effective in the long-term provision of service may have the following characteristics:

- **Broad eligibility:** *looking at only age and/or income. It does not recognize assets and it does not target those most in need.*
- **Prioritization:** *looking at who has been waiting the longest for help, not at who has the greatest need.*
- **Need:** *looking at what a person is unable to do but not at where there those needs may be met through caregivers and other supports.*
- **Professional Service Provision:** *looking at what can be authorized through a comprehensive provider network but not at what can be accomplished by piecing together a network of informal supports.*
- **Addressing deficits:** *looking at what the person is unable to do and filling those gaps with services, but not at what might be accomplished by setting goals for improvements.*
- **Limited capacity to serve:** *capacity is limited to the amount of funding available to pay for services it does not maximize the use of funding by targeting those services that are crucial to independence and leveraging community support to provide those services that are needed but not critical.*
- **Waiting list:** *capacity is limited and those with immediate needs must wait until additional funding is available or attrition occurs and an opening becomes available.*

A system with the above characteristics is likely to provide many services to few individuals.

***The new system will focus on a person centered approach to working with clients. It builds on the strengths of a robust ADRC and provides an enhanced Options Counseling and Case Management service.***

Hallmarks of the new system include:

- **Personal accountability:** *Reliance on the individual's willingness to use their own resources to pay for their care.*
- **Enhanced resource management:** *With support from their Home Care Manager, clients will be encouraged to identify their support network and maximize all other resources before relying on state and federal support.*
- **Identification of critical needs:** *Targeting resources to meet the critical needs only for as long as they are needed.*

- **Leveraging resources:** *Leveraging of community funding, volunteers and fund development to meet identified non-critical needs through enhanced information management systems.*
- **Empowering:** *Clients work with their Home Care Manager to improve their health or personal situation by establishing attainable goals.*
- Authorizing only services that are needed, thereby reducing care plan costs and enhancing our ability to serve more.
- **Immediate access:** *Providing services to those most in need when the help is needed.*
- **Face to face access:** *Providing benefits and options counseling face to face rather than relying solely on a phone assessment.*
- **Action Plan:** *Providing the client with a road map to meet their needs by outlining their options, if they have the ability to direct and pay for their own care.*
- **Follow up:** *comprehensive follow up to insure that the action plan was appropriate and that the needs have not changed.*

Comprehensively changing the way we deliver service is what the two Area Agencies on Aging set out to do. It is timely given our funding environment and it is also timely given the influx of older adults who are expected to need assistance in the future. In our approach to creating change, we sought to make every system responsive and meaningful with an eye to the future.

**By implementing a change in approach with targeted precision, we hope to be able to give consumers what they need, when they most need it.**

## INTAKE AND TARGETING (Previous Process)

When an individual contacts the Area Agency on Aging for assistance, they enter through the ADRC. In that interaction, the ADRC determines initial eligibility based on self declaration of functional deficits.

The eligibility determination, based on the number of functional deficits and/or income, was in need of revision. We sought to develop a “most in need” model for determining who would receive services, as opposed to a “first come, first served” approach.

**During our initial examination of the current process we realized that our current tool was not effective for prioritizing need, nor would it appear to address need at all.**

Indiana had been utilizing the MDS-HC to determine eligibility in another case management program. Wishing to improve the eligibility determination to target those most in need, the scope of the grant was expanded to include piloting a new method. Our new assessment process would begin with the MDS-HC tool and be used as a means to identify those who were most at risk of nursing home placement and then to target care for those most in need.

To begin our research on an improved system for triaging we looked at the MDS-HC model through the University of Michigan. Indiana has a history with this program, utilizing for their Money Follows the Person model. In discussion with the University of Michigan it was determined that this software would be cost prohibitive for eventual expansion to the entire Indiana ADRC network, , necessitating research for the development of our own tool for evaluating a person's ability to live independently and prioritizing those who need assistance.

ADRC 2 began to look at Indiana's current tool, an eligibility screen that requires a certain number of ADL or IADL deficits to trigger eligibility for a Medicaid Waiver and Indiana's CHOICE program. We compared the eligibility screen to the screening tools of several other states and organizations, notably Connecticut, Florida, Arizona, New Jersey, Ohio, Kansas, New York Minnesota and the MDS-HC. (See: Attachment C)

## THE PRIORITIZATION TOOL

A Prioritization Tool (See: Form A) was developed and underwent numerous revisions before it was finalized. This document was developed as a tool to triage callers and determine where the greatest need lie rather than relying on a "first-come first-served" model. Once finalized, the document was used in addition to the e-screen so that comparisons could be made

at the end of the grant period. It would be our intent that the Prioritization Tool could replace Indiana's eligibility screen. (See: Attachment D)

Early in the planning process we worked with Robert Applebaum, PhD and researchers with the Scripps Gerontology Center at Miami University Ohio, in completing an evaluation of our client data. (See: Attachment E) The resulting document entitled "Use Patterns of Home Care Participants: The Experiences of REAL Services" reviewed the records of 1549 participants in Indiana's Medicaid Waiver and CHOICE programs. The Scripps researchers reviewed data on those individuals whose care needs had changed and who were no longer able to live independently. The data was evaluated to determine the indicators of decline which might be considered "risk factors" in future consumers.

**Scripps Gerontology Research Center, Miami University Ohio**  
**Executive Summary of Findings (REAL Services Home Care Program)**

- REAL Services home care participants report high levels of functional disability, averaging between two and three major activity of daily living impairments, with more than one in five impaired in four activity tasks such as bathing and dressing.
- Although long-term care is often thought of as primarily an issue affecting older people, about half of Medicaid Waiver participants are under age 65, and one in five is younger than 18.
- Personal care and home making services are mainstays for this population, with half of the participants receiving such services. Six in ten receive emergency response equipment.
- Social supports are critical for this population, with more than nine in ten participants reporting friends or relatives willing to provide assistance.
- Self-directed participants report higher levels of disability (42% four or more ADL limitations versus 30%) and slightly higher levels of family involvement compared to regular Medicaid Waiver enrollees (99% versus 93%). Regular waiver participants report more severe medical conditions (14% versus 6%) and a higher need for medical equipment (13% versus 4%).
- Three quarters of Waiver participants were still enrolled after one year, and 42% participated for three years or longer. Six percent were enrolled for 100 days or less. The median length of stay for those enrolling was 446 days.
- The major reasons for leaving the waiver program are nursing home placement (41%), death (37%), and other (22%), which includes such options as moving out of the area or moving in with relatives.

- In reviewing those leaving the program to enter nursing homes, we find these individuals to be more likely to have entered REAL Services from a nursing home (18% vs. 11%), are more likely to be older (72 vs. 52), more likely to be women (74% vs. 58%), and more likely to live alone (46% vs. 26%).
- A nursing home predictor model was used to examine the odds of nursing home placement and found that for individuals age 60 and older the most important predictors were lack of caregiver support, (twice the odds of placement), needing assistance with daily tasks as a result of confusion (three times the odds of placement), and needing assistance with groceries (five times the odds of placement). The predictor model for those under age 60 found slightly different factors. In addition to caregiver support (three times the odds of placement), gender was important (women had five times the odds of placement), and those entering from a nursing home were nine times more likely to leave for nursing home placement.

Use Patterns of Home Care Participants: The experiences of REAL Services, Robert Applebaum, Ian M. Nelson, and A. John Bailer, March 2011.

We drew from a wide variety of sources to identify those areas where a deficit would point to a potential threat to independence. We also developed a level of deficit scale like the specialized assessment Indiana had developed for Foster Home, Adult Day Services and Assisted Living assessments. The scale Indiana developed employed a graduated level of functioning which provided a clearer assessment of the person's deficit level rather than a strictly "yes or no" response. In this grant we used the model of graduating levels of impairment and introduced it to a functional assessment. The example below demonstrates the two approaches that would be applied to an individual with a cognitive impairment.

Indiana's Eligibility Screen	Prioritization Tool
The person requires 24 hours a day supervision and/or direct assistance to maintain safety due to confusion and /or disorientation.	<p>COGNITION:</p> <p>0- Always oriented to person, place, and/or time. No difficulty remembering or using information</p> <p>1- Person is showing signs of cognitive decline, but is able to function in familiar or new surroundings with occasional caregiver support. May have short term and/or long term</p>

	<p>memory problems but responds to cueing.</p> <p>2- Decision making is severely impaired. While the client can still live independently, the client needs daily support and reassurance while change is being discussed, when decisions are being made, and while changes are being implemented.</p> <p>3- Disoriented to the point that the client cannot live independently. Requires 24 hour supervision to maintain client's health and safety.</p>
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Based on the data from the researchers at Miami University, we added additional “risk factor” evaluations and provided the opportunity for additional points if the participant indicated any of the triggers.

Those triggers were:

- Persons age 85 or older;
- 11 years or younger with a skilled need;
- Currently residing in a nursing home or in the nursing home or hospital within the last 30 days;
- Currently considering nursing home placement;
- Reported caregiver stress level based on self-declaration;
- Caregivers who are feeling overwhelmed and have no one able to assist; and
- Participants who have no caregiver.

In addition to the enhanced level of deficit, we realized that the current eligibility screen did not address need. Eligibility is based on the number of deficits but did not take into account whether or not that need was being met or at what level that need was being met. For example, if a person had a cognitive decline at a level of 3 but had adequate support at home, there may not be a need. Eligibility could then address raising or lowering the score of the individual based on whether or not a need existed.



**The numerical score on the Prioritization Tool does not become a doorway for eligibility as it is currently with the requirement of three checks on the eligibility screen, rather it becomes an indicator of the overall client situation; need takes precedent over eligibility in determining who receives assistance.**

A modified point allowance was added to address informal supports that were short term. For instance, when need was addressed by Medicare funded services but were only short term, additional points could be awarded that would recognize the additional support without penalizing the individual for having short term support.

## TARGETING

As we contacted and met with clients using the prioritization tool and our new approach to defining need, we began at the bottom of our wait list. Our thought was that those who had been waiting longest should be offered help first.

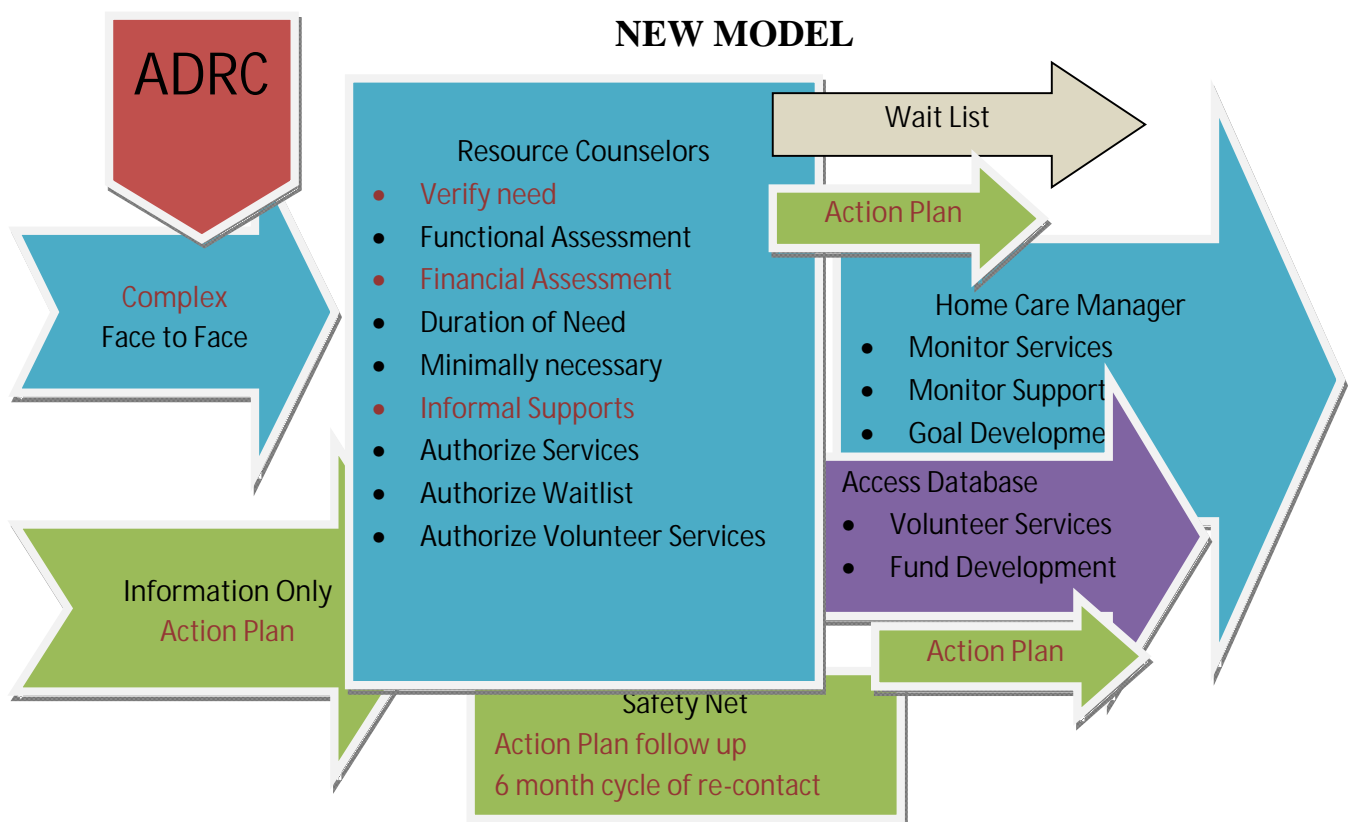
When we had hired our third Resource Counselor, we could diversify our approach, strategically targeting those who were at the top of the list. Our final step was in targeting folks who were actively seeking help from the ADRC.

## A MORE ROBUST ADRC

With an age wave on the brink of our network, we knew that we had to develop another system for addressing the needs of older adults and those with physical disabilities. Our intent then was to determine how to replicate the person centered approach to the ADRC operations, implemented in Area 12, and to build on the strength of the Options Counseling program in Area 2.

We speculated that a responsible approach in assisting those who need services would be more accurate if a face-to-face were conducted rather than a phone assessment. We set out then to 1) determine the accuracy of the current system versus the more costly option of providing face-to-face options counseling, and 2). explore a new approach that would rely on a more robust

ADRC experience followed by a face-to-face meeting for those with unique challenges or more extensive needs.



## DETERMINATION OF NEED

*Staff was encouraged to look at each individual's unique needs and not what is required to determine eligibility. Need is a significant factor driving a care plan and should reflect a person's desire to remain safely in their home.*

Through the Prioritization Tool we developed a method for determining a more accurate picture of the person's ability to perform ADLs and their abilities related to maintaining independence, by determining levels of ability versus the YES/NO responses. Additionally, we developed a method for ranking need that took into account whether that need was currently being met by an adaptive aid, through caregivers, or some other means.

Triaging provided a method for determining those who had the highest need and minimal or limited resources and insured that those individuals were served most promptly and in some cases immediately.

The determination of need would be based on the evaluation of what was critically needed and whether or not there were other sources that could meet that need. Need would then be defined as having a functional deficit that would impact an individual's inability to live independently and/or their health and safety. The determination of whether or not that individual would receive funding assistance for providing for those needs would be determined by a review of their current support system.

Working with the individual to determine their ability to utilize their own resources was the next logical step. The individual would not receive funded support services if:

- The person has the ability to self-pay
- Their informal supports could be coordinated in a way that would adequately provide for their needs.
- The caregivers were managing care safely and without unmanageable stress.

***Those who would receive supportive services would be individuals who have health and safety needs that were not, and could not, be met using their own resources - even with the help of a "systems navigator". This is how we defined who we would serve with funding, however every need would be recorded and addressed.***

## CRITICAL VERSUS NON-CRITICAL SERVICES

Those services that provide us with the ability to remain independent and living safely in the home are "critical" services. Critical needs are identified as a service that is needed to keep an individual out of a nursing home and ensure their safety in the community.

When critical needs were identified, a "Plan of Care" (POC) with agreed upon services, vendors, and designated hours were authorized. If non-critical needs are also identified, an "Action Plan" was created in addition to the Plan of Care.

<b>CRITICAL NEED</b>	<p>A critical need is defined as one that is integral to insuring a client's safety and/or well being. A critical need is also a service that is needed to keep an individual out of a nursing home and ensure their safety in the community.</p> <p>A critical need is not necessarily a skilled service or a hands on service. A critical need service must be defined in the context of the client's situation.</p> <p>An individual who has skilled needs may not have any "critical" needs.</p> <p><i>Example:</i></p> <p><i>Ms. Smith has no one to do her laundry and she is unable to manage the stairs safely to take her laundry downstairs. Without the ability to wash her clothing she may consider moving to a nursing home to insure that she receives the minimal help she needs. In this case, Homemaker is a critical service for Ms. Smith</i></p> <p><i>Ms. Jones has a difficult time cleaning her home. She manages but it takes her a long time. She could use some help with deep cleaning and even with some of the regular cleaning on days she's not feeling well. In this case, Homemaker is a non-critical service for Ms. Jones.</i></p>
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Non-Critical Needs are defined as those that would enhance the client's quality of life but are not necessary to keeping them living independently.

When non-critical needs are identified at the initial home visit, the options counselor outlines an "Action Plan" with the client. The non-critical needs should then be reported back to be entered into the database.

Non-critical services are real and important, and should not be ignored. For this reason, those needs had to be documented in a way that allowed easy and organized management of information. Information documented in the Non-Critical database was maintained and used to identify alternative resources to meet the need. Appropriate referrals to the database were very diverse, someone to paint walls or need for a pen-pal. When the non-critical need is documented it allowed volunteer services and fund development to work on meeting the needs in an alternative manner.

An example of this is Mary who needs a PRSM (Personal Emergency Response / Safety Monitor) due to a high fall risk. In addition to this critical service, Mary needs a homemaker to help her with her holiday cooking. She has always made cookies for her grandchildren and she is no longer able to do this. Mary could be served even with this “non-critical” service by linking her with a volunteer, church group or school group who is hoping to do a special project for the holidays.

Another example could be Mike who would like help with his bill paying. He has been reliant on his sister who has been ill and not always able to assist Mike. Mike could be linked with a volunteer, a local bank or a member of his informal support group. Mike’s case manager added his need to the Non-Critical Needs database. In the meantime, Mike and his case manager established a goal to identify someone in his informal support group who could assist. Mike identified a friend of his who he contacted and was able to help until Mike’s sister could continue once again. The case manager submitted to the database that the need had been met and the need was removed.

## PROCESSING NON-CRITICAL NEEDS

The following is the process developed for recording non-critical needs for Resource Counselors:

1. Complete the “Request to Meet a Non-Critical Need” form.
2. Place “Benchmark Form”, “Prioritization Tool”, “Request to Meet a Non-Critical Need” form and the “Action Plan” on top of other paperwork in the file.
3. Turn the file into the Client Needs Analyst for review.
4. Once this review has been completed, the file will be returned. At this point, mail the “Action Plan” along with any additional resources to the client.
5. Remove the client from any wait lists (notify Client Needs Analyst and Client Data Specialist), if there are no crucial needs.
6. Turn the file into a Case Aide as an “inactive wait list client.”
7. Note the Follow-up date so one can contact the client at a later date as indicated.

## AUTHORIZING SERVICES IN A NEW WAY

Not every individual's needs are the same, even among those with identical circumstances and/or diagnoses. Each individual will cope with their situation in a different way and their care plan should reflect their unique need in the context of their own abilities and value system.

Services should therefore be “fluid”, meaning that there is no formulated manner to authorize services.

For instance, rather than authorizing 4 hours of care 1 time per week for a small apartment, you may authorize 2 hours 2 times per month only to wash floors because this is the portion of homemaking the person is unable to complete.

The case manager was encouraged to reduce services when it was determined that the services are no longer critical to keeping the individual safe. The notion that services are available only for as long as they are critical to health and safety should be an ongoing discussion between the case manager and the client, which helps reinforce the case manager's decision to reduce services at the appropriate time. Clients who received services during rehabilitation should be encouraged by knowing that their funding can be used to help another who is still working toward improvement. Additionally, those who have worked on regaining their independence should be encouraged to take pride in their accomplishment, rather than become reliant on care.

Services should always and only be authorized because they are critical to a person's health and safety. Care plans should reflect those services, and only as long as they are needed. Need drives the entire care plan, not eligibility.

Care plans require understanding the client's prognosis, with the result being:

- It alerts the consumer that their services may be short term.

- It communicates that we hope to see them improve and that the case manager, options counselor, and ADRC personnel will work with them to see that happen.
- It allows us to terminate services based on when we reasonably expect that person to no longer need services.

This is especially true in cases where there is a short term event, like a recovery from a stroke or surgical procedure. There is no reason for us to assume that a person will continue to need services long term, even after returning home from a nursing home or hospital admission. Any savings to our long term care funds allows us to serve more, with priority to those with acute and critical needs.

## THE ACTION PLAN

The “Action Plan” (See: Attachment F) contains all information discussed with the client and their family regarding their care options. The “Action Plan” is a road map for the consumer to follow that gives them information on where to go for the help they need, and may also include;

1. an acknowledgement that a referral has been made to the volunteer services program;
2. details on discussion that helped them to identify their informal supports;
3. steps they will take in getting informal supports more involved or coordinated;
4. a reiteration of those community resources or agencies that the client may qualify for;
5. contact information on “fee for service” options if the client or their family members are able to privately pay for care

The “Action Plan” also details information on follow-up at a later date. Staff was instructed to make certain the consumer understands what it states, and also understand that we will be following up with them to determine if they were able to use it in arranging for their care needs.

The “Action Plan” may be the sole service we provided or it could have been used in conjunction with a plan of care that provides for services that meet their critical needs.



When the “Action Plan” is the sole service provided, the client was informed that they would be removed from the wait list. If the client was not on a wait list, they were told that their needs can be met through following the “Action Plan”.

The client was reassured that if his/her situation drastically changes in the future, we would return to re-evaluate their need for services or to provide additional assistance in meeting their care needs.

Information on how to contact the ADRC was provided to the consumer, and the consumer was always asked if we could follow up with them to make sure they are doing alright.

## THE ROLE OF THE RESOURCE COUNSELOR

<b>RESOURCE COUNSELOR</b>	<p>A resource counselor is a trained geriatric care manager who has received extensive training on benefits counseling and resource mapping. A resource counselor is the first face of the ADRC and meets with those who are in need of assistance to:</p> <ul style="list-style-type: none"><li>a). explain options;</li><li>b). identify all financial resources;</li><li>c). determine resources that may be unique to the individual;</li><li>d). determine the level of need an individual has;</li><li>e). map out all non-financial resources to meet the needs of the individual prior to authorizing state and federal funds to provide care.</li></ul>
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Once the direction was clear, we addressed the question of who would be best suited to implement a new process for determining those who would receive care. In our past experience of implementing a private pay case management service, we found that it was extremely difficult for staff to make a paradigm shift in the traditional case management model successfully. With that experience in our minds we opted to look for an individual with no previous case management care coordination experience.

We focused our attention on identifying a new skill set and then finding the right candidates who had the ideal experience. We looked for candidates who were comfortable, and had experience in having discussions related to personal income and resources. Candidates with a financial background and who also had experience in a non-profit work environment were ideal, and so the job description was developed (See: Attachment G).

Listed below are the highlights and key duties of the Resource Counselor position:

### **SUMMARY**

This full-time position is responsible for initial face to face assessment of client needs and resources. The Resource Counselor establishes services to meet the individual's critical and non-critical needs through the formalizing of supports and authorizing paid services when needed.

### **ESSENTIAL DUTIES**

- Meets with the client to establish need and identify potential resources
- Verifies the individual's income and assets.
- Identifies critical versus non-critical needs.
- Authorizes care plan services to meet critical needs, for the time needed.
- Transitions the client to a Case Manager, for ongoing case management as needed.
- Explains the intake process and the services program to the client.
- Provides benefits counseling to help identify all potential resources.
- Provides services within a person centered framework.
- Follows up to insure care is meeting the client's needs prior to transition to a home care manager.
- Uses resources wisely, assuring services are cost effective and appropriate.
- Refers individuals to services available through community agencies and organizations; to meet the agency's mission of client service and accountability.

### **RESPONSIBILITIES**

A Resource Counselor is responsible for performing activities that insure access to all services from which a client might benefit. Resource Counselors make recommendations for community services or alternate living arrangements based on the needs of the individual in their care.

Resource Counselors must be well versed in the various community resources and programs. It is essential that work is completed in a quality and timely manner, in accordance with program standards or guidelines.

Our interviews focused on identifying clients who possessed a comfort level in discussing finances with people and who were receptive to training. Even with this additional attention to finding unique skill sets, the culture presented challenges and the Resource Counselors were eventually taking on traditional case management positions.

The Resource Counselors were trained on those issues that were most critical, such as how to determine need and how the process would work. (See: Attachment H) and they were provided a basic training manual that would address some of the issues that they would face and gave them a sense of how the process would work for them (See: Attachment I)

With no history to rely on they were instructed to bring their concerns and questions directly to leadership. Based on their experiences the process would be modified as new information was learned. Initially the Resource Counselors were given an overview of how the process would work. The overview of the process shared with Resource Counselors is noted below:

#### **THE ADRC**

- Assesses need
- Assesses resources
- Options counsels
- Gives an overview of what the Resource Counselor will do
- Advises the caller to pull financial information together (See: Attachment J)
- Identifies any additional persons who should meet with Resource Counselor
- Refers to the Resource Counselor

#### **INITIAL CONTACT WITH CLIENT**

- Calls client within 72 hours to establish initial visit
  - Review the process
  - Review the documents needed

#### **INITIAL CLIENT VISIT**

- First visit should occur within 5 business days of initial contact
- Gives an overview of the process
- Verifies the clients need for assistance
- Identifies all needs, both critical and non-critical

- Identifies all resources, formal and informal
  - Completes benefits counseling if applicable
  - Reviews Medicaid eligibility
  - Provides information on Medicaid
  - Reviews community resources if applicable
  - Review private pay options
- Verifies income and assets
- Discusses critical needs with client
- Discusses resources available to meet critical needs
- Discusses resources available to meet non-critical needs
  - Identifies unmet needs
- Explains cost share process, if applicable
- Develops an Action Plan
- Develops a plan of care (person receiving ADRC funded services or cost share)
  - Authorizes critical need service(s)
  - Client signs an acknowledgement of resources
  - Services begin within 10 business days of meeting
- Explains the process and timelines in greater detail with roles of Resource Counselor and Case Manager
- Provides Case Management
  - introduction information

## **FOLLOW UP**

- Follows up with client one week from when services were scheduled to begin
- Notifies Case Manager of the upcoming transfer
- Follows up every 7 days (minimum) if services have not begun or problems identified
- Follows up on any outstanding financial information needs
- Follows up on any Medicaid application needs (if applicable)
- Keeps Case Manager apprised weekly of expected transfer date

## **TRANSITION TO CASE MANAGER**

- Transitions after financial information is gathered and verified
- Transitions after critical services are in place and stabilized
- Contacts Case Manager to give client contact information
- Case Manager has 72 hours to make contact with client to schedule visit
- Schedules a transition meeting with Case Manager
- Provides transition sheet to the Case Manager
  - Discusses identified needs
  - Discusses resources
  - General overview
  - Supports identified

## **CASE MANAGER POST-TRANSITION ROLE**

- Follows up with the client in 30 days

## TRANSITIONING TO A CASE MANAGER

Early in the process of developing this pilot, we designated specific individuals, at least one from each county in our service area, to be trained as liaisons. These individuals were giving training and supported in understanding what we were trying to accomplish. The purpose in this was to develop “champions” that would be available to provide support to their peers and to help increase understanding of the effort. We anticipated concern from the staff based on previous experience in managing change.

The liaisons were the case managers who also received the clients who were served through this grant, to provide ongoing case management services. They needed to be aware of what we were trying to accomplish so that they could ask questions and help guide us as we continued to refine and develop our efforts.

As a way of helping the client transition we did three things:

1. Introduce the client to the process;
2. Introduce the case manager they would work with; and
3. Provide a seamless transition from Resource Counselor to Case Manager.

As the Resource Counselor explained the process to the client, they also explained the role the Case Manager would eventually play, and how that differed from their role. Our intent was to help the client to understand that the Resource Counselor’s role was primarily related to a function and the Case Manager’s role was more of a relationship and a facilitator.

To begin to bring case management into a person-centered care model, we determined that it would be helpful for the client to have information on the case manager they would eventually be working with. Each Case Manager Liaison was asked to complete a brief bio and a photo they would be willing to share. This was all optional but encouraged. We experienced no difficulty with the staff on sharing this information and actually found that the information had to be edited down so that the Case Manager was not too identifiable. (See: Attachment K). Once

edited, the information was developed into a single sheet that was shared with the client at the time that it was evident that the consumer client would receive services and need an on-going Case Manager. (See: Attachment L)

Once the client's care had begun and they were ready to transition to the Case Manager, the Resource Counselor completed a transition document (See: Attachment M). The Case Manager and Resource Counselor reviewed the document together and if possible arranged a joint visit with the client to insure a thoughtful and person centered transition.

The goal of the Case Manager was to meet with the client soon after the transition and check that services were continuing to go smoothly and to begin working on goals that might address the non-critical needs as well as other areas where the clients health or quality of life could be improved.

Resource Counselors were advised to follow the procedure below in transitioning to the Case Manager:

- Once the signature page is received, finalize the POC Worksheet into a Care Plan and services can be authorized to begin:
- Fax the Notification of Service Authorization (NOSA) to the vendors and complete file processing;
- Stay in contact with the vendors and client within the first two weeks after the official Care Plan start date to ensure that services have started and are going well.
- Once you have determined that services are going well, complete the "File Transition to Home Care Manager" form.
- Contact the HCM either by phone or do a face-to-face meeting. Review the client's needs, any actions you have taken, and give a general overall picture of the client's situation. Also notify the HCM of the follow up date so that they can complete this task.
- Notify the HCM if a Non-Critical Need was identified so that they can begin to integrate that and the "Action Plan" into Person-Centered Planning with their next visit.
- Pass the file to the HCM.

### **A REVISED COST SHARE SYSTEM:**

Area 2 and *LifeTime* Resources proposed establishing a new cost share system that would ask more of the individuals receiving care, but still remain manageable for the consumer. We sought to develop a process that was both consistent and equitable. A component of the new system would be to build in a slower progression to Medicaid eligibility, as a means of slowing the rate of impoverishment required to become eligible and to ensure that adequate resources were maintained to allow the person to remain in the community.

### **COST SHARE CHART**

The cost share chart (See: Attachment N) was revised and required cost share to begin at 102% of poverty rather than the 152% previously used in Indiana. This document was used to determine a cost share only for income.

### **DEDUCTIONS FOR HOUSING**

The deductions allowed for housing were based on Medicaid allowed deductions. Wherever possible, our information was developed to mirror Medicaid. Deductions were allowed for utilities used for heating, water heater, water and sewer. (See: Attachment O)

### **ASSET COST SHARE DETERMINATION**

Once total assets had been determined, a percentage was provided based on amount determined. (See: Attachment P)

Slowing the progression to Medicaid would delay the opening of the gateway for Medicaid to pay for additional services, such as medical care, food stamps and other benefits, thereby saving the State of Indiana's Medicaid funding. For that reason, a base was determined that assets would not drop below. The intent was to protect enough assets that an individual could manage to pay a medical bill or repair a roof without completely depleting their resources.

### **INCOME AND ASSET ANALYSIS OF AVAILABLE CONTRIBUTIONS**

This documents looked at all income sources, potential deductions and assets. The Asset and Income cost share percentages were added together and this determined the final cost share amount. (See: Attachment Q)

Instructions were also developed to help the staff understand the various income and assets we were measuring. (See Attachment R)

If it appeared that the person may need services to be authorized, we verified their resources. If the individual was determined to have the ability to contribute, they would be told that they will be required to share the cost of their care.

If a cost share is determined, that amount was shared with the client. They would also be informed that if their resources decline suddenly, we could revisit the determination at any time. The cost share would be revisited regularly, so even minor changes in income or assets would result in a reduced cost share percentage.

We required a greater level of participation and accountability on the part of the consumer. Through person centered care, the ADRC would work to identify all resources available and insure that critical needs were met to our greatest ability.

The greatest change occurred in development of a document that would address the inclusion of assets and resources. The CLP grant provided us with the opportunity to test a model that brought together both assets and resources to be combined into one amount. Like Medicaid, this amount included assets that had not yet been liquidated, but could be.

The proposal included some key elements:

- The determination of a single cost share amount that represents assets and income.  
The proposal put forward integrated resources and assets into a single available amount. That amount represented all the resources that an individual has available to contribute to the cost of their home care.
- The ADRC verified those assets and then recorded them.
- The ADRC was able to identify and verify all available resources including non-financial assets.
- A new cost share level  
When a single amount had been identified, a new cost share process was implemented that was more aggressive than the current cost share. Cost share could be modified as resources diminished or as other changes impacting income, occurred.



- A threshold which will protect sufficient assets to maintain a home.  
In order to insure that individuals are left with adequate resources to maintain themselves in the community, a threshold was established under which a person would not fall.
- Greater emphasis on person centered care in the determination of an individual's goals.  
Person centered care required that the Case Manager, along with the client, establish goals that all parties agree to abide by. The Case Manager responsible for providing support in meeting the goal and the client were responsible for maintaining obligations as well. The client's obligation included paying a portion of the cost of the care that all parties agree are needed. The goal included better managing their chronic disease so that less service would be needed over time.
- A revision to the allowable deductions.  
We looked at the current deductions and tried to have them mirror Medicaid to the best of our ability.

## **VERIFYING RESOURCES**

At the home visit, Resource Counselors were required to verify income and assets. This was done to determine what funding sources they may be eligible for. Additionally, resources were verified so we could arrive at a cost share amount if applicable.

If the client is already on Medicaid, we did not verify their income or their assets. This process is the same even if a spend down is in place.

If the client was not already on Medicaid, then he/she was required to apply. Depending on the client's wishes, they or a family member could go to their local Medicaid office to apply or complete the application online. In order for services to begin, we needed to verify that an application had been submitted – we did not wait for an approval or a denial to begin services (this was for the Case Manager to follow-up on).

If the person was unable to help in verifying their income due to cognition or other issues, and they were in an unsafe situation, it was permissible to approve services first to make certain there were no concerns for endangerment. After the person's care was stable, we

continued to verify income and assets. In this case we informed the client that we were presuming their eligibility but that they may be required to pay a cost share retroactively.

The Resource Counselor was responsible for following up on any outstanding resource verification prior to transferring the client to a Case Manager.

When the Resource Counselor experienced difficulty in verifying resources, they were instructed to assist the client and/or their family in gathering the required information.

If the person was on Medicaid, there was no need to verify resources. When the individual on Medicaid had a spend down, the person was exempt from cost share.

### PERSON CENTERED CARE

Person centered care means focus on the specific person and their unique needs versus a systems approach. Rather than dealing with funding sources eligibility we address meeting needs. Rather than maintaining clients we focus on establishing goals for improved outcomes based on the at clients individual situation.

In helping the staff change to person centered care model, we developed a statement explaining what this meant for us as an organization and the philosophy behind it. Our hope was that this mission statement would appeal to the values of the staff. If that were the case we believed we could make the change more easily.

*Person centered planning shall be used as a method to incorporate the specific interests, needs and desires of a client into their overall service planning. At all times a client shall be treated with respect and given a clear explanation of the services or options available to them. Indiana's person centered philosophy also includes listening to the client and helping them set goals outside of their service plan. The tracking and documentation of goal progression and other meaningful events is critical to ensuring that the client's desires remain a valued part of the service planning and service delivery process."*

<p style="text-align: center;"><b>PERSON CENTERED CARE</b></p>	<p>Person centered care shall be used as a method to incorporate the specific interests, needs and desires of a client into their overall service planning. At all times a client shall be treated with respect and given a clear explanation of the services or options available to them. A person centered philosophy includes listening to the client and helping them set goals outside of their service plan. The tracking and documentation of goal progression and other meaningful events is critical to ensuring that the client's desires remain a valued part of the service planning and service delivery process.</p> <p>The concept of person-centered care is not new it has a long, well documented and successful history with disabled individuals. The concept of person-centered care that is used to work with the older adult population may be similar; however the method used to implement the concept is significantly different.</p> <p>Person-centered care goals have centered on non-institutional living, integration and employment. The research tends to focus on community integration, acceptance and the use of tools for identifying networks and supports to accomplish individual goals. To the older adult population, maintaining or regaining independence is often the primary goal. Socialization, which can have both a significant physical and emotional impact on quality of life becomes centered on the maintenance or rebuilding of relationships. Personal management of one's health involves identifying measures that can be taken to enhance their control of a chronic disease. This self-management not only empowers the person to improve their own functioning, but is likely to better enable them to accomplish other non-health related goals.</p> <p>The Case Manager and client now work together in partnership, to maintain or improve the quality of life for an older adult in a way that has specific meaning to them.</p>
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## PERSON CENTERED CARE FOR THE RESOURCE COUNSELOR

For the Resource Counselor, we focused on a consumer conscious process that provided for smooth transitions and a thoughtful review of resources and assessment of strengths and weaknesses. The Resource Counselor was also alerted to be aware of the condition and stress of all caregivers involved.

In this new process the Resource Counselor becomes the first face of the organization. Their role is to offer navigational services and to act as a temporary lifeline to the client and their family until the person's situation is stabilized. They are focused on securing accurate and detailed information from the client and their caregiver. They are also the primary individual who insures that the safety net is extended appropriately.

The following was used as training with the Resource Counselors to insure that they were thoughtful in their processing of client cases:

## CLIENT START-UP PROCESS

### PRE-CONTACT

- Remember these communication tips:
- Talk slowly;
- Don't talk to the client while they are signing a document;
- Don't assume a level of understanding exists, ask the person if they have understood what you've presented;
- If you're unsure, politely ask to have it repeated back, (example: "I know I've given you a lot of information today, can you tell me what you plan to do to move forward?")

### INITIAL CONTACT

1. Review any preliminary client information, including wait list file (if applicable), or referral, doc notes, and e-screen.
2. Call the client to discuss their need for in-home services and schedule an appointment for an initial assessment. If your information indicates that the client has dementia or a mental illness, then it may be best to also call an emergency contact if one is available. You should strongly encourage the client to invite any individual they believe would have an interest in their care or who would have a role in the decision making process. If you are not able to get the individual to agree to meet with you, always ask if you may send them information on how to contact the ADRC and any other resource information that may seem advisable. Also ask if you may follow up with them by phone periodically to make sure they are still doing alright and to keep them in the safety net.

### UNABLE TO CONTACT

The intent is to make an extra effort to insure we have done everything possible to reach the individual or their contact.

1. If the call was made to the client's home and you had to leave a message, call back after 2 days (Day 3 of having the file). After the second message is left without response, (Day 5 of having the file), you should try to reach emergency contacts or informal supports.
2. If you are unable to reach an emergency contact or support, research additional options for phone numbers/address. You may also consider trying to contact the original referral source if appropriate.
3. Accessing online sources such as whitepages.com, 411.com, or even the Medicaid web interchange, may get you the information you need. Use these resources to verify the accuracy of the address and/or phone. If a physician is listed in the client's records, they may be able to assist in contacting the individual.

4. If the needs were significant at the time of the client's original call, you may elect to do a "cold call" home visit.
5. A letter should be sent to the client notifying them that they have been removed from the waiting list, with an effective date. The letter should also contain information on how to take corrective action if there was an error or if they have a concern.

## THE HOME VISIT

Begin by telling the client what the process will be, (you can also do that by reviewing the process sheet with them) and what you will do for them:

1. You will assess their need for assistance and eligibility for help.
  - a. provide information, support and access to benefits and community resources.
  - b. help with understanding their options for long term care.
2. You will identify all needs, both critical and non-critical.
  - a. Help understand all their care needs so that a plan may be developed to meet those needs.
3. You will identify all resources, formal and informal.
  - a. Help them maximize their resources.
  - b. Help where their resources are not sufficient.
  - c. You may authorize critical services
4. You will verify their income and assets.
  - a. They will know what services if any, they may qualify for.
  - b. Benefit programs they may be eligible for.

## PERSON CENTERED CARE FOR THE ADRC

<b>OPTIONS COUNSELING</b>	<p>Options counseling is an interactive decision-support process whereby individuals, family members, caregivers, and /or significant others are supported in their deliberations to make informed long-term support choices in the context of the individual's preferences, strengths, needed services, values, and individual circumstances.</p> <p>The Options Counseling process facilitates person-centered, streamlined access to supports and includes the following components at the direction of the individual: gathering information about his or her current situation, providing information on and educating about long term support options, weighing pros/cons and potential implications of various options, collaborating to develop a long term support plan, facilitating enrollment in participant directed services, assisting with enrollment in publicly funded services, assisting in connecting to privately purchased and/or informal supports, and following-up with the individual.</p>
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For the ADRC, person centered care meant:

- Establishing need and interacting with the client in a way that insured the best outcome;
- Following up with 100% of those we work with; and
- Being more aggressive in determining the individual's resources including their ability to assume responsibility for the cost of their own care.

The ADRC staff was already tuned into the notion of person centered care as a normal function of their workday. They were able to embrace the idea of personalizing care and could see improvements in processes immediately. For example, the fact that we mailed out applications and waited for their return before we put someone on the waiting list for assistance seemed backward. If an individual was already struggling to remain independent, especially if they have a cognitive impairment, how likely would it be that they would complete the necessary paperwork and return it in a timely manner. Those who were least likely to be able to follow processes through to the end were also likely to be one of those who are most in need of help. Person centered care would provide a new philosophy to change that process. Those who were

cognitively impaired could be seen almost immediately in person, and receive advice and assistance with navigation, and an action plan – and help with completing paperwork as needed.

We attempted to provide the Resource Counselors with a preliminary sense of how the work would flow.

- Normally, a call would come in through the ADRC and the person receives options counseling.
- If the individual still needed home care the ADRC staff sent a wait list application packet for the consumer to complete and return.
- If the packet is returned the consumer is placed on whatever waiting list they are eligible for and they wait for a “slot” to open before they may receive services.

The following information was provided to them to give them a sense of how work would flow and where there would be obvious changes. We asked them to review the information and bring forward questions or concerns. We heard few questions, what we did hear would be addressed in an FAQ and sent out to all staff.

## ADRC – INDIANA'S SINGLE POINT OF ENTRY SYSTEM

**GOAL:** Through education, access to information and navigation, to assist those with resources, as well as those with limited or no resources, to effectively and efficiently provide for their long term care needs.

### ***Hallmarks of this process:***

- Ø The need for a comprehensive shift in culture to person centered service provision;
- Ø The development of skills that enable us to comfortably have discussions about sensitive issues;
- Ø Verifying need not eligibility;
- Ø A vigorous commitment to early intervention and planning; and
- Ø The creation of a “safety net” intervention for all older adults regardless of income or ability.

## **OPTIONS COUNSELING**

- Determine the type and extent of need.
- Provide information on what might meet that need (community resources and care coordination).



- What appears to best match their individual situation and ability (person centered)
- What are the pros and cons of each option

### **FINANCIAL NEED**

- What are income and assets (the extent of their resources)
- What informal supports are in place
- Benefits counseling
- How close they are to Medicaid eligibility (waiver and other benefits)

### **OUTCOMES:**

- If appropriate, an action plan (may also be an interim intervention).
- Direction or assistance on how to coordinate care and/or how to pay privately.
- Private case management to navigate or direct care.
- A “call back” as one thread of the safety net.
- Access to the Resource Counselor.

### **ACCESSING THE RESOURCE COUNSELOR**

- Client requests a face to face visit (with good reason)
- Unsure about need. (level of care)
- Cognitive problems or problems understanding
- Waiting list appears to be only option
- Person appears waiver eligible (Medicaid and need)
- Requires a higher level of counseling and is unable to come to in to meet face to face.

### **PERSON CENTERED CARE FOR CASE MANAGEMENT**

Person centered care in an aging environment is a relatively new approach to insuring that care is individualized and responsive to the unique situation and needs of every consumer. Models have always targeted those with disabilities and focused on community integration, employment and education. The model then for older adults had to be responsive to their needs which are significantly different than a younger disabled individual. For the older adult, goals that focus on maintaining or regaining independence, quality of life, and management of chronic diseases are more meaningful.

For case management, person centered planning means working with existing clients to enable them to improve their health, maintain their independence, and improve their quality of life through the establishment of unique goals and working with them to insure progress is being made to the best of their ability.

The Resource Counselor should have already discussed with the client, the expectation that we will work toward independence. They have already discussed the expectation that they will be establishing goals with their case manager, and the purpose of that process being to help them to improve as much as possible so that they realize an improved quality of life.

The process of goal setting was one portion of our plan to build a culture of independence around the client. The establishment of goals, even the smallest goal, has been proven to be the most effective tool in fighting depression, an affliction often found in older adults.

Another efficiency was realized in the coordination of care, a purview of case management. The effective coordination of care for an individual is at the heart of case management in its truest form. Care coordination takes the case managers role to a level of navigator by assisting the individual in putting together the pieces of the puzzle to build the whole picture of care.

Coordination of care is critical to an efficient system. Blending the efforts of informal supports, paid service, and any other supports available, is an efficient use of resources. Whenever clients have a need, it is worth examining if putting together the puzzle for the client would help them meet their need. Certainly when we talk about providing 24/7 care, we know that this is not feasible under paid care. This is when we may consider that nursing home placement is the best or only option. However if we are able to help the client piece together their resources to meet their needs, 24/7 service is possible. This coordination of care would

include informal supports, formal supports, insurance coverage, self-pay, and any other resource the client has access to.

LifeTime Resources developed a manual for their staff to outline the new processes and help case managers understand their opportunities as Options Counselors (See Attachment S).

## GOAL DEVELOPMENT

We sought to establish a case management system that was built on a new “aging version” of the person centered goal development model. This new model was designed to help consumers realize their maximum potential rather than accepting aging as an on-going decline, and to change the Home Care Manager’s role to that of a facilitator and as a resource to promote positive change.

To help the staff understand the changing role of a case manager from a “broker” of services to a person centered model, we developed a policy on what Person Centered Case Management was. Below is the purpose statement from that policy.

*“We believe in caring for those we have been charged to serve and in creating a safety net to protect vulnerable older adults while insuring our ability to continue to serve those who have yet to reach us. We also believe that in carefully authorizing only what is needed to keep an individual safe while working toward creating independence to the maximum degree possible, we preserve resources to serve those most in need and those who have immediate needs.*

*In order to serve those who have the greatest need and to provide for those who immediate needs, we must look at our service delivery system with a critical eye. We must find ways to serve people better, while relying less on state and federal resources. Caring for more people with fewer resources requires that:*

- we encourage each individual to be as independent as possible;*
- we provide what is needed rather than what the person is eligible for;*
- we create efficiencies within our service delivery processes;*
- we must require that those we serve to take as active of a role as possible in ensuring that their care needs are met.;*

- *we assist clients in maximizing their individual resources.; and*
- *provide individualized client care that is person centered.”*

Additionally, Case Management staff were provided with a basic primer on what Person-Centered Planning involved. The following is an excerpt from that manual. The entire document is available (See: Attachment T).

The concept of person-centered planning (PCP) is not new. PCP has a long, well documented and successful history with disabled individuals. The concept of PCP that is used to work with the older adult population may be similar; however the method used to implement the concept is significantly different.

PCP goals have centered on non-institutional living, integration and employment. The research tends to focus on community integration, acceptance and the use of tools for identifying networks and supports to accomplish individual goals.

To the older adult population, maintaining or regaining independence is often the primary goal. Socialization, which can have both a significant physical and emotional impact on quality of life becomes centered on the maintenance or rebuilding of relationships. Personal management of one's health involves identifying measures that can be taken to enhance their control of a chronic disease. This self-management not only empowers the person to improve their own functioning, but is likely to better enable them to accomplish other non-health related goals.

The Case Manager and client now work together in partnership, to maintain or improve the quality of life for an older adult in a way that has specific meaning to them.

## What is Person Centered Planning?

Person centered planning focuses on establishing goals and working with the client to meet their self identified goals through Case Management.

Older adult case management has historically focused on assisting a person to manage independently for as long as possible by providing in-home services, referring to community services and assisting with access to those services. This has been done by using routine services that support an individual with physical limitations by doing “for” them and making their limitations easier to live with by providing them a service to fill that limit.

In Person Centered Planning, the Case Manager first works in partnership with the client to identify areas of deficit in their total environment, not just their physical functioning. This process is much more holistic, taking into consideration their mental and physical wellness, their level of socialization and even their ability to navigate their physical environment.

### **A COMPARISON OF DIFFERENT APPROACHES TO CLIENT CARE**

<i><b>System Centered</b></i>	<i><b>Person Centered</b></i>
Identify all deficits – what the client can’t do.	Begin with a goal that moves the person in a positive direction based on their abilities.
Tell the client what services they qualify for.	Identify assets to help the person meet their goals and direct care.
Authorize services from a pre-determined list of allowable services.	Meeting needs through both formal and informal supports.
Responses are reactive, we fix things when they go wrong and as issues arise.	Responses are proactive, goals are established that empower and support the client.
We see limitations based on limited functioning or funding availability.	We see opportunities for improvement and growth.

Client is responsible for following through on our suggestions or referrals.

Case management partners with the client to support them.

Fill deficits with home care services.

See the total environment in which a client functions and maximizes all resources available.

Care plans resemble all other care plans.

Care plans reflect unique interests, needs, and goals outside of standard, prescribed services.

Needs don't typically address "softer" needs such as socialization or personal interests

Addresses the total person which includes the environment in which they function

## THE ASSESSMENT TOOLS

Tools were developed for the Case Manager to use in introducing the client to person centered care and the establishment of goals. These tools were to be used to enhance their efforts and not as a mandatory form. The intent was to use them as a means to build a closer relationship with the client and to understand how they are motivated and be better able to help the client define their goals. A better understanding of who the client is and what motivates them would help the Case Manager be a better facilitator and advocate.

## Mapping Supports and Relationships

Reviewing the map of supports (Forms Attachment U) is intended to engage clients in meaningful conversations regarding those people whose input they value. These are the same individuals who the client may wish to invite to the meetings to discuss goals, supports and who can help them meet these goals.

Included in the supports mapping should be those who are involved in any way in providing care to the consumer. Partner meetings would be encouraged so that all the individual's supports understand and agree to a specific role in providing care and additionally support the goals the consumer has established. (See: Attachment V)

We used the *Mapping Supports and Relationship* to identify these individuals with the client. They may be friends, family or institutions such as a church or former employer. These relationships also included professionals and others who provide care for the client.

### Individual History and Profile

With this document we were trying to get a picture of what the person's daily life is like (Forms Attachment W), their challenges as well as their successes. This helped identify functional and emotional challenges and abilities and how their support services could assist with or support meeting their needs.

The outcome is to learn how this person lives. If it was comfortable for the client we would engage them in conversation about their personal history. In the end we hoped to have a better sense of any struggles they have in their daily functioning, as well as their likes and dislikes.

We also tried to determine their personal preferences, special talents and interests. Talents might include things like strength of will, persistence, or passion.

Case Managers were not required to ask each question, but that they try to get sufficient understanding of the individual.

## Home and Mobility Assessment

The home and mobility assessment (Forms Attachment X) looks at how each individual is able to navigate in and around their home. It also addresses the client's safety inside, outside and even within the neighborhood.

The first portion of the assessment includes discussion over affordability and proximity to needed services. Staff were encouraged to have a discussion about whether or not the person wants to age in place.

The second section identifies mobility devices and whether or not they are used. The third section addresses their ability to complete specific functional tasks. The discussion could include why the person is not able to accomplish these tasks. There may be devices or therapy that could assist the client in regaining some abilities. In this section they are able to identify how difficult the task is to complete.

The final portion is a general review of the functionality of the home. Safety as well as mobility issues are identified here. The client could identify those tasks or accessibility issues that they feel are most critical. At the end of the document the Case Manager has the ability to work with the client to prioritize from all those points that were identified as "change now". Those priority areas could become their first goals for independence.

## Wellness Assessment

This is the assessment that helps to identify personal goals (Forms Attachment Y). Often these areas, considered "soft" needs, are really critical to how we determine our quality of life. After having completed the *Wellness Assessment* with an individual, we hoped that the Case Manager would have a better sense of where deficits in these areas will have the greatest impact. For instance, if the client's happiest days and best parts of their life were their interactions with family and they no longer take the time to enjoy them or participate in family functions, it may



be safe to assume that they feel this loss. Likewise if the person has always been an introvert, the fact that they do not socialize much may mean that they are content with that part of their life and do not wish to change it.

## The Caregiver Assessment

The caregiver assessment (Forms Attachment Z) was to be completed with each family member providing support, if possible. This was intended to provide the Case Manager with a sense of what the caregiver currently contributes, and if there is more they may be able to do of if they need support to be able to continue.

Having the caregiver see our role as assisting them in the management of the individual's specific care is beneficial to them as well. *They may benefit from being able to rely on our experience, expertise and ability to provide support that might have otherwise fallen on their shoulders* (i.e. helping them to arrange care in the event of a change in status, helping them through problems with Medicaid or arranging doctor appointments). Anything we were able to do to support the caregiver, also supported the client and ultimately prolongs the consideration of nursing home placement.

## Establishing Goals

Personal Goals – (Forms Attachment AA) These goals may be an outcome of the wellness assessment or from normal conversations with the client. These goals are more directed at the quality life for the individual.

Goals for Independence – (Forms Attachment BB) Goals for independence tend to look at the environment in which the person lives. We assess their mobility as well as how effectively their home meets their current needs. Access to needed services, family and friends are all a part of this assessment

Health Management Goals – (Forms Attachment CC) These goals seek to maintain or improve one's disease management. We tried to help them find ways to take some control over the disease even if it is only by becoming more educated on the disease itself.

## Using the Assessments to Identify Goals

Each assessment has the ability to contribute some insight into what goals may be helpful and relevant for the individual. The idea for a specific goal may also come from the natural discussion between the Case Manager and the client. It may be something they have always wished they could do, or do again, but were previously unable to do.

The assessments are tools to assist in the process of setting goals but they are only tools and should be used only if it brings value to the client and/or the process. The main purpose of the process is to enhance quality of life and have the client engaged in the process of determining and taking greater ownership of their care needs, if possible.

## Using the Goals to Manage Outcomes

All goals were maintained in a database (See Attachment DD) that could alert the consumer's case manager to dates when particular activities were to be completed. This served as a reminder to staff to touch back with the client to review progress. If the goals were not being met the dates could be revised or the goal could be amended (See Forms Attachment EE). In either regard, the case manager's role as facilitator is supported and they have a tool in managing the outcomes of multiple clients and multiple goals.

## FOLLOW UP

In a person centered care model, follow up is critical. We determined immediately that we wanted to create a comprehensive safety net that would insure those taken off the waiting list and those whom we had contact with would be able to easily maintain ongoing contact with us. We determined that this was best done through an extensive follow-up plan.

Every client who was contacted regardless of whether or not they received any services or said they had no needs, were asked if they could be re-contacted in 6 months. In six months they will be called and the end of that conversation will include a request to contact them again

in another six months. It is our intent to keep that person in a safety net until they determine that they no longer need or want our involvement.

We have begun to categorize follow up calls to insure that clients who have received information or action plans are called to follow up soon after the information is shared. We see that as also an investment in keeping our information accurate as well as an issue of customer service.

## WHAT WE LEARNED

### Benchmark Reports

As we began to work on documents that would track our progress and research we developed a form called the Benchmark Report (See: Forms FF). In this document we received summary information on the Resource Counselor's experiences as they moved through the process with each client. Much of this information was used in our various research compilation and analysis.

In general we offer the following information:

Those who were Medicaid or Medicaid pending	48 %
Those who were Medicaid Waiver eligible	18 %
Those who had non-critical needs	38 %
Number of successful face to face visits after initial contact	56%
Closed out (no home visit)	76 %
Number receiving services	36 %
Those receiving an Action Plan	54 %
Total number served in Person centered care	652

Total number of prioritization screens completed	173
Total number of Participant Directed Clients	126

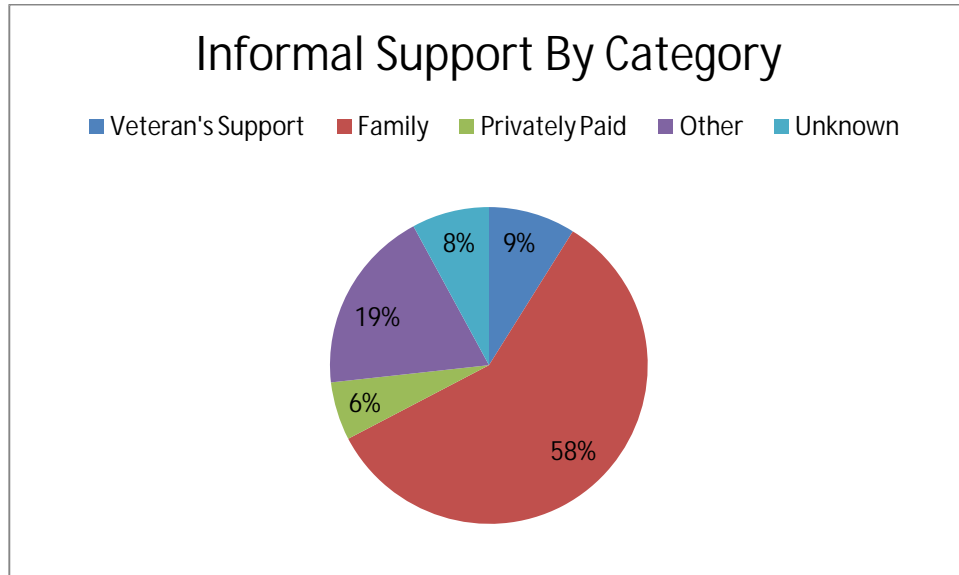


Figure 4: Informal Support By Category

With each contact we tracked the informal supports that played a role in supporting the individual. Not surprisingly the results showed that 55% of contacts were assisted in some way by their informal supports and more than half of those are family members.

This supports the notion that coordinating and supporting this extensive network should be a part of any fiscally responsible plan to serve and support older adults.

<b>SOURCE</b>	<b>Percent</b>
Family	58%
Other (including assisted living)	19%
Veteran Programs	9%
Unknown	8%
Privately Paid Services	6%

## Study of Reported Informal Supports

- Family Providing Care
- Privately Paying
- Other Supports
- Veterans Administration Services
- Children Providing Care
- Spouse Providing Care
- Family and Private Pay Assistance
- Unknown
- Assisted Living
- Veterans Administration and Private Pay
- Veterans Administration and Family

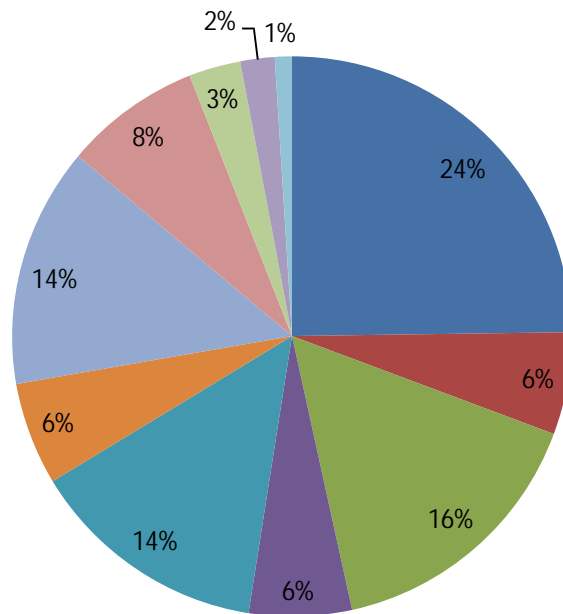


Figure 5: Study of Reported Informal Supports

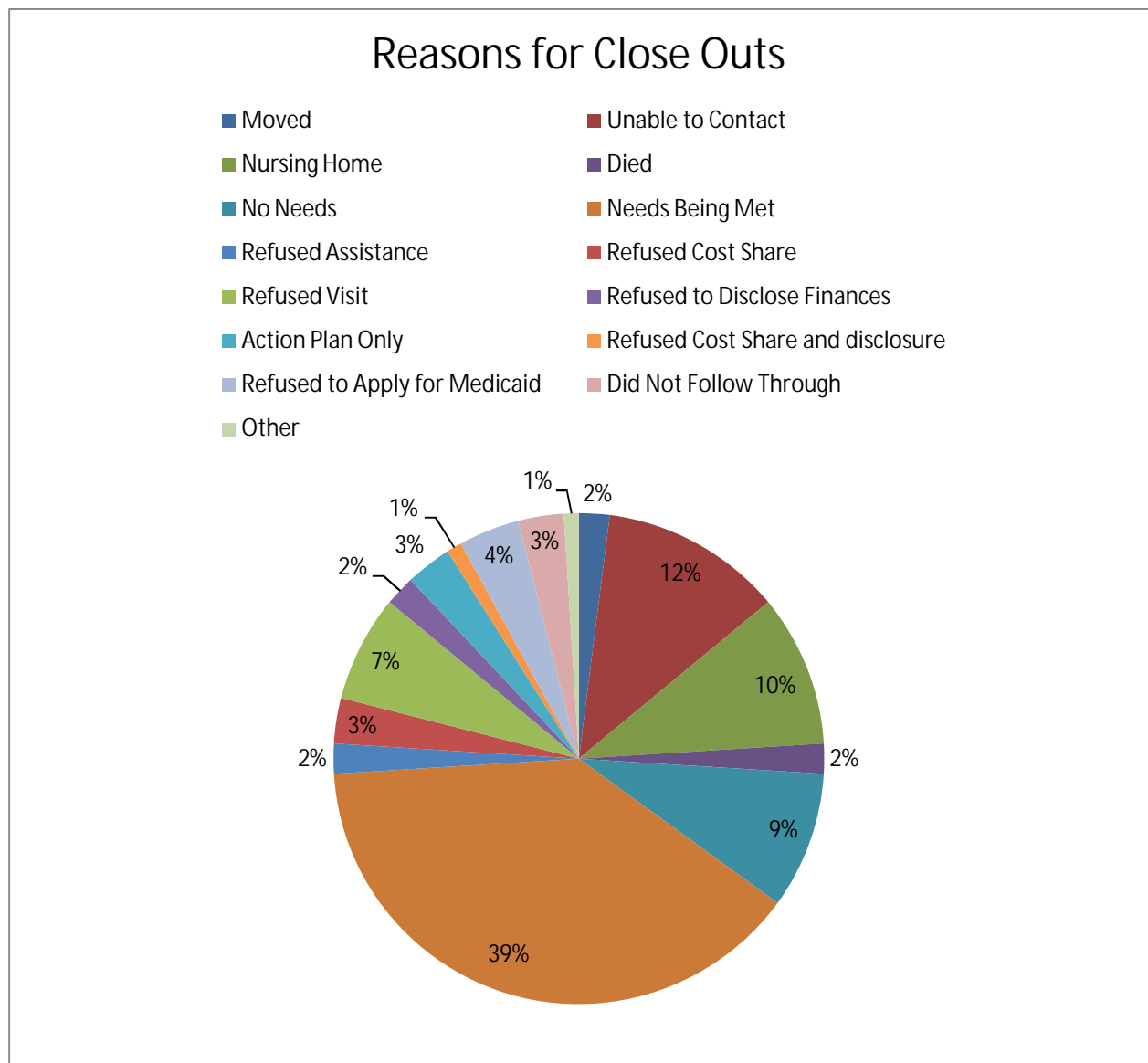


Figure 6: Reasons for Close-Outs

Those who did not receive services as a result of the contact and/or assessment, were also reviewed and studied. We broke them into three categories: 1) those we had no control over, 2) those who refused in some manner and 3) those that were closed out but served in some capacity

Those who were served: (TOTAL 51%)

- This includes those who only received an action plan
- Those who had no needs but were offered support through the ADRC
- Those whose needs were being met who were also offered contact through the ADRC if their needs changed.

Those who were unable to participate due to circumstances beyond our control: (TOTAL 30%)

- Those who died
- Unable to contact
- Moved
- Entered a nursing home
- Didn't follow through
- Other

The third category were those who refused in some manner: (TOTAL 19%)

- Refused cost share
- Refused to disclose finances
- Refused a visit
- Refused assistance
- Refused to apply for Medicaid

## FACE TO FACE

### ACCURACY OF NEED BY PHONE ASSESSMENT VERSUS FACE-TO-FACE

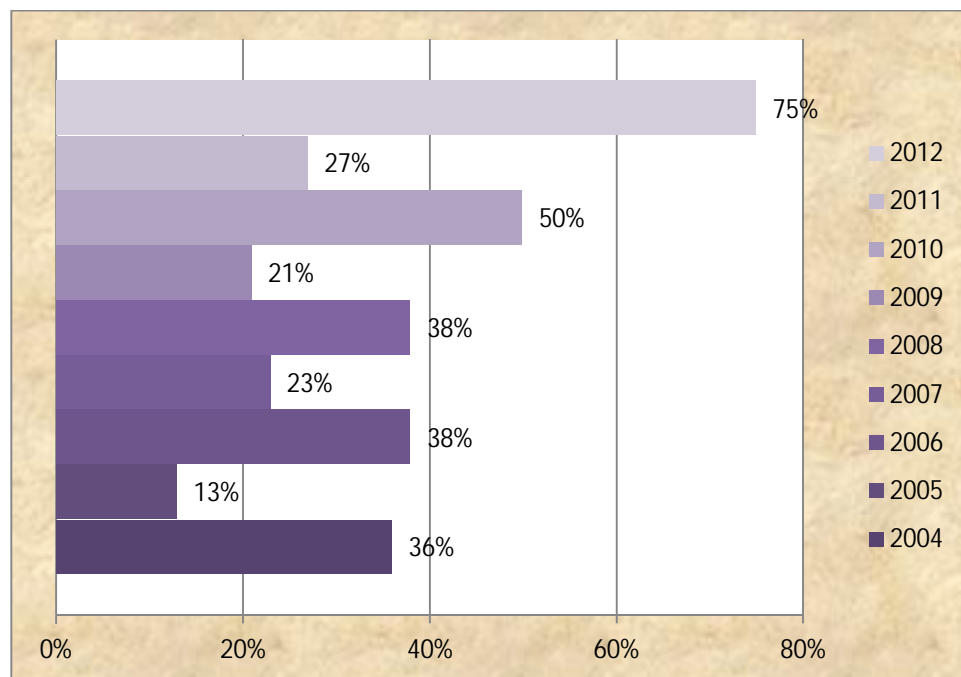


Figure 7: Need Accuracy Over Time

This would suggest that:

- The longer someone stays on the waiting list the more likely they are to find another avenue to meet their own needs or they will improve.
- The need for an approach that supports short term care plans

- The need to educate clients that their services are only going to remain for as long as they are truly necessary.

## CALLER PERCEPTION OF NEED VERSUS ACTUAL NEED

The following information was obtained from 125 telephone calls to the ADRC requesting assistance. In these cases, the needs the caller requested were those recorded by the ADRC staff based on the information the caller provided. The caller/referral source may or may not have been the intended service recipient. The ADRC recorded based on information provided by the caller or a request for a specific service that the caller made and the ADRC verified as a need.

The Resource Counselor verified need based on a home visit intended to discuss the client's specific situation and then to work through the individual's actual needs.

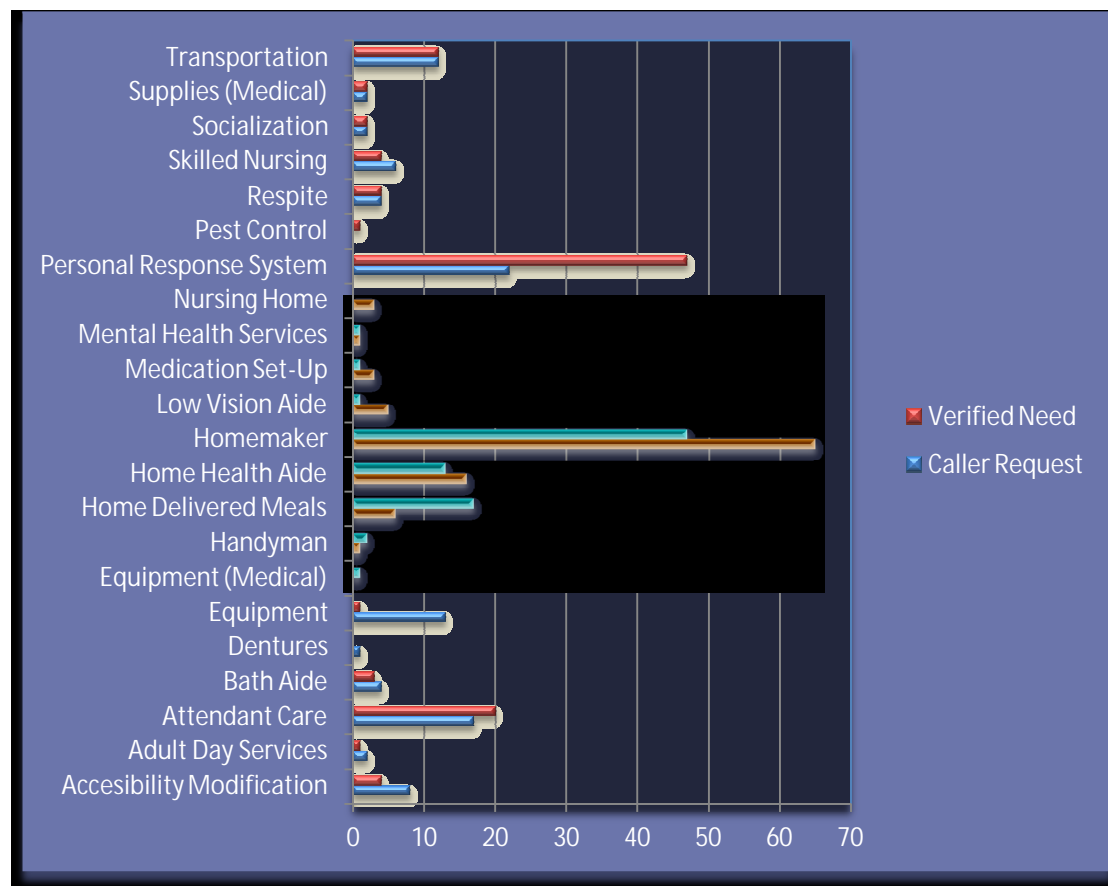


Figure 8: Caller Perception of Need Versus Actual Need – By Service Type



Of note, Homemaker services were most often requested by the caller. The number of requests for homemaker services -- totaling 66-- were more than three times the request for any other service and represented 52% of the total requests. Resource Counselors verified this need far less often. Homemaker as a needed service represented only 38% of the total services needed, when verified by a Resource Counselor based on a face to face visit.

Conversely, the Resource Counselors were much more likely to see Personal Response Units and Home Delivered Meals as services that were critically needed. Personal Response Units were identified in 38% and Home Delivered Meals in 14% of home visits. This need was identified only 18% of the time for Personal Response Units and for 5 % for Home Delivered Meals by the caller and ADRC staff based on the telephone assessment.

Interestingly, as detailed in figure 8, the top five services identified by either the phone assessment or the face-to-face home visit were in most cases, the same services. Exception happened in two service areas. Callers identified Home Health Aide at the same rate as Attendant Care, but the face-to-face visit did not corroborate Home Health Aide in the top five identified needs. The service that was identified by the face-to-face visit that was not initially presented was Home Delivered Meals.

It may be that the caller had a pre-conceived idea of the services they believed were needed and influenced their discussion with the ADRC staff accordingly.

**NEED IDENTIFIED  
BY PHONE ASSESSMENT**

**NEED VERIFIED  
BY FACE-TO-FACE VISIT**

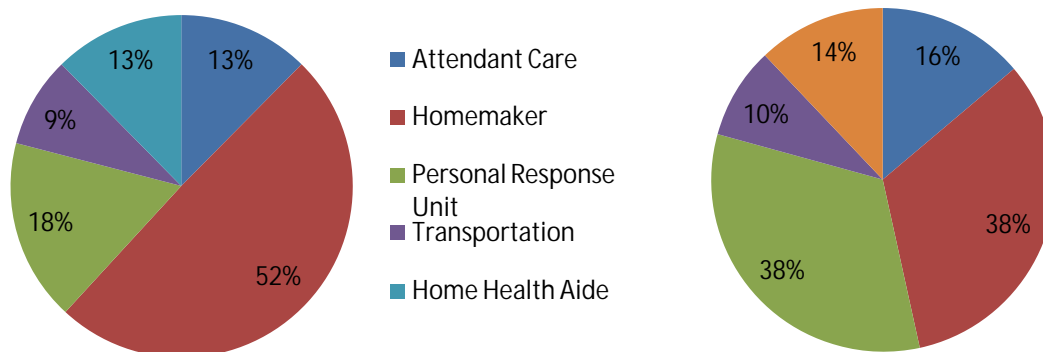


Figure 9: Needs Identified by Phone Assessment Versus Face to Face

**ACCURACY OF ASSESSMENTS BY PHONE IN DETERMINING  
SERVICES NEEDED  
AFTER A FACE-TO-FACE VISIT**

	Needs Unchanged	More Services Needed Than Presented	Less Services Needed Than Presented
2004	18%	36%	46%
2005	13%	13%	74%
2006	38%	38%	24%
2007	15%	23%	54%
2008	38%	38%	24%
2009	26%	21%	42%

<b>2010</b>	0	50%	50%
<b>2011</b>	41%	27%	32%
<b>2012</b>	25%	75%	0

Figure 10: Accuracy of Assessments By Phone in Determining Services Needed After a Face to Face Visit

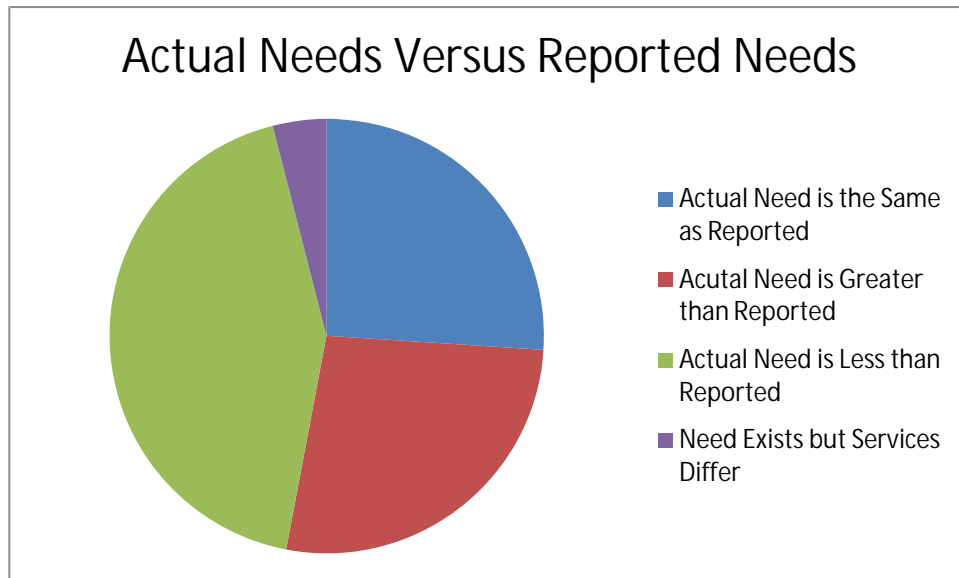


Figure 11: Actual Needs Versus Reported Needs

The accuracy of the assessment was also tracked by year to determine if accuracy was improved with more recent information. It does appear that in 2012, as the needs were determined within two weeks of the phone call, the accuracy was improved. 2012 was the only year when there were no instances when the face-to-face visit indicated less needs than initially presented. In fact, it should be noted that in 2012, 75% of the cases resulted in more services needed than was initially determined by phone assessment. This may indicate that callers underreported the extent of their need and/or functional deficit.

Previous years do not appear to show any correlation between accuracy. In other words, a longer time between phone assessment and a face to face visit did not impact the accuracy in a way that would make it less or more accurate.

## ELIGIBILITY SCREEN ACCURACY BY PHONE ASSESSMENT VERSUS FACE TO FACE

During the pilot, the E-Screen eligibility tests, which identifies functional deficits, were completed by phone as a part of the intake process. During the phone call, the ADRC staff request specific information that identifies the needs of the individual for whom the referral is being made. Based on the information provided, an initial determination was made on the potential eligibility of the individual and they were assigned to specific wait lists according to that information.

The Resource Counselors completed an identical E-Screen eligibility test during their face-to-face interview with the individual. The intent was to test the accuracy of placing an individual on the wait list based on information provided by telephone.

The data regarding E-Screen accuracy indicated a significant difference between phone call reports when compared to the face-to-face verification. In a comparison of E-Screen outcomes from 111 experiences, only 28% of calls accurately assessed the callers' functional deficits.

- In 62% of reports given by phone, needs were reported to be greater than what was verified.
- In 28% of the cases, the needs reported by phone were identical to what was verified in a face-to-face contact.
- In 10% of the cases, the face-to-face experience indicated that needs were greater than what were reported by phone.

Whether due to the ACRC staff wanting to assist the client in receiving help, or the caller reporting an inaccurate accounting of the individuals needs, the data indicates that the face-to-face determination of need is a more accurate indication of what the individual requires.

## Accuracy of E-Screen Reporting

### Telephone versus Face-to-Face

Same Need Phone Greater Need Face-to-Face Greater Need

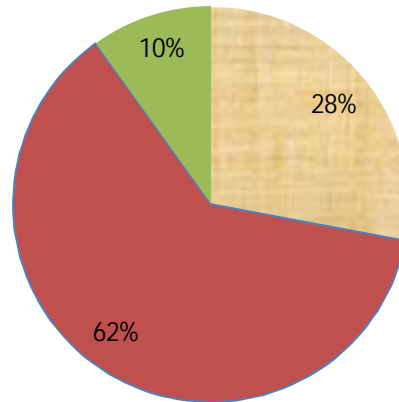


Figure 12: Accuracy of E-Screen Reporting

## THE PRIORITIZATION TOOL

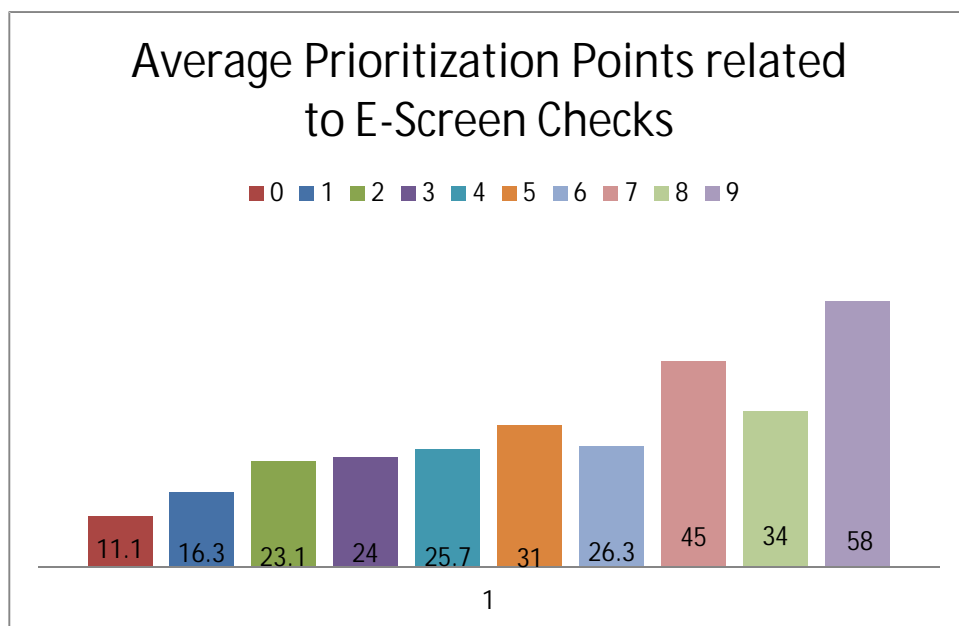


Figure 13: Average Prioritization Points related to E-Screen Checks

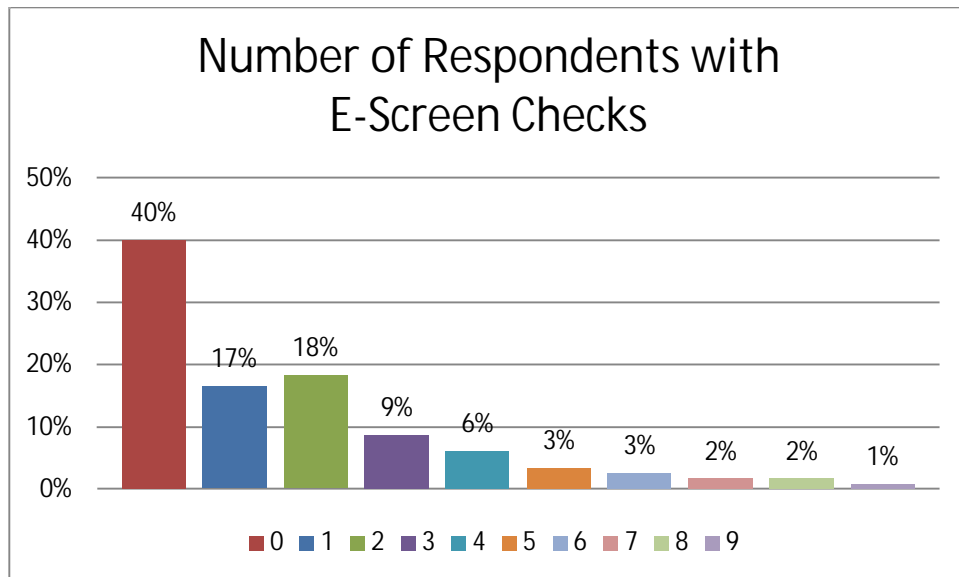


Figure 14: Number of Respondents with E-Screen Checks

Both the prioritization tool and the E-Screen were completed during the home visit. The intent was to show any correlation between the two documents. Were either able to quantify

through a point system, an actual need. Would a number on the Prioritization tool or checks on an E-Screen surface as an indicator of need?

E-Screen Checks	Average Prioritization Points
0	11.1
1	16.3
2	23.1
3	24
4	25.7
5	31
6	26.3
7	45
8	34
9	58

Figure 15: Comparison of E-Screen Checks to Average Points

Results indicate that both are related but neither surfaces as a document that would be an accurate based on a numerical figure. The Prioritization tool however seems to provide more valuable information and addresses to what level the needs are being met in each functional deficit category.

The numbers appear to indicate that the largest group of individuals contacting us are those with low needs. There could be any number of reasons for that to occur:

- People realize there is a waiting list and don't feel they can wait
- People are calling early to investigate what's available
- People are calling to get on the waiting list now so they have help later when it's needed.
- We are not targeting our message as well as we could

- There are more services available elsewhere for those with acute needs.

## ANALYSIS OF HIGH RISK FACTORS

In our addressing of how an Area Agency could best triage through the use of the prioritization tool, we looked at the risk factors identified through the Scripps study, based on research from INsite, Indiana's Case Management data system. (See: Research E) We then broke the lack of caregiver support, identified in the research, into further categories including stress level, where there was a single caregiver and where there was no caregiver present. Those risk factors were:

- A person age 85 or older;
- A child with a skilled or medically complex condition;
- Someone who had been discharged from a hospital or nursing home within the last 30 days;
- A person who was requesting nursing facility care;
- Those reporting caregiver stress; (level 2, 5 and 10 self declared)
- A single caregiver providing support; and
- Someone who had no caregiver.

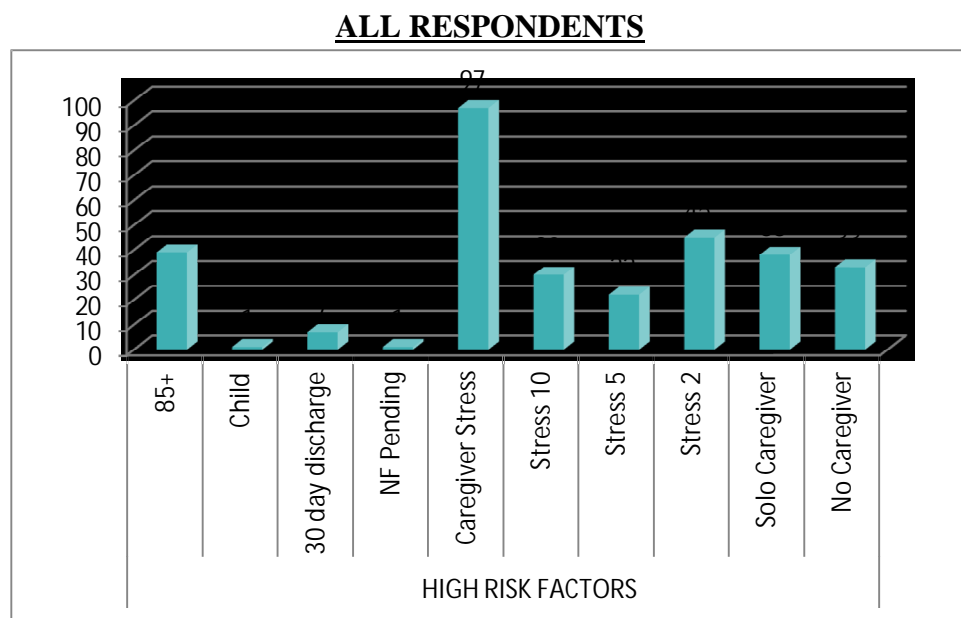


Figure 16: Analysis of all Respondents indicating a high risk factor



Looking at the data regarding risk factors we can see that the highest risk factor by far is caregiver stress. The levels of stress indicated are a subsection of the overall Caregiver Stress as indicated above. Those who reported the lowest level make up the largest group of individuals reporting stress. Second to Caregiver stress is the 85+ and where there is insufficient caregiver support. This is contrary to what we might have expected. We fully expected that the nursing facility or hospital related risks would be the primary indicator of those who contact us seeking support.

Of those who we interviewed for this study, all were evaluated for elements of the risk factor criteria that might be present. Overall 87% of those contacted had one or more risk factors present, however those with an unmet need in managing their functional deficits score were 97%.

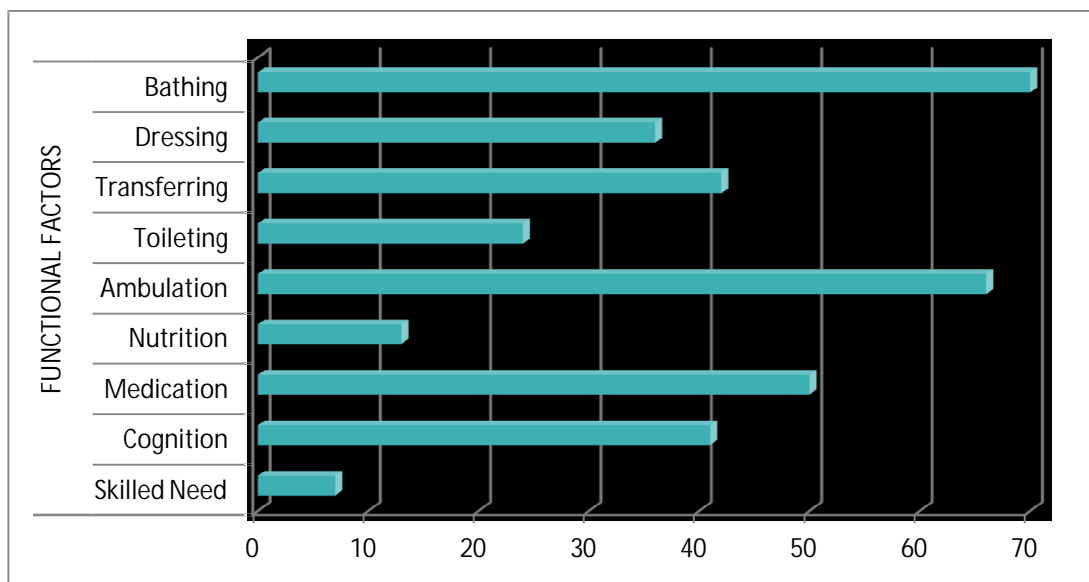


Figure 17: Analysis of all Respondents indicating a functional deficit area

When we reviewed the areas of functional deficits we were again surprised to see the findings. Bathing and Ambulation were clearly the areas where consumers were experiencing the most difficulty. Looking more closely at those categories we see:

Risk Factors for All Respondents		
<b>Total with high risk indicators 87%</b>	Percentage of the total assessed	Number of respondents
<b>Bathing</b>	43.8 %	60
<b>Ambulation</b>	43.1 %	59
Medication	31.4 %	43
Cognition	26.3 %	36
Transferring	24.8 %	34
Dressing	21.9 %	30
Toileting	14.6 %	20
Nutrition	8.8 %	12
Skilled Need	4.0 %	6

Figure 18: Risk Factors for all respondents

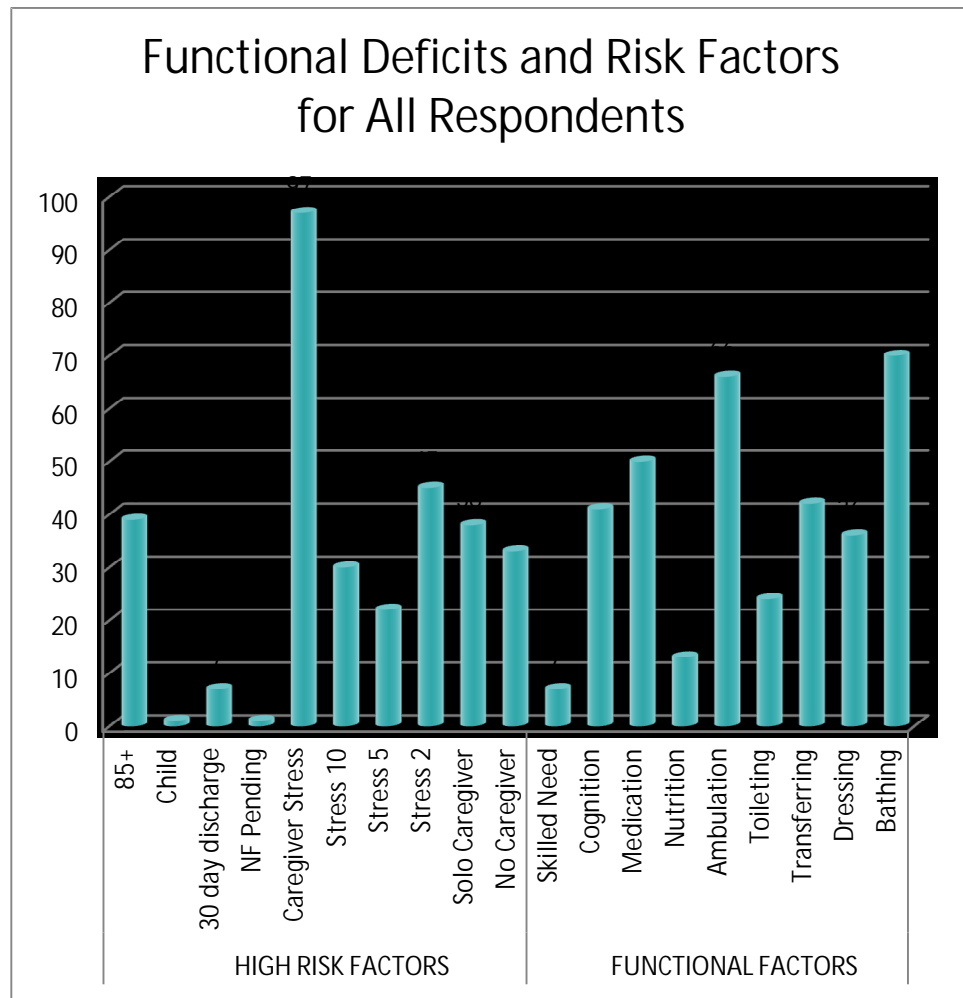


Figure 19: Analysis of the Functional Deficits and Risk Factors for All Respondents

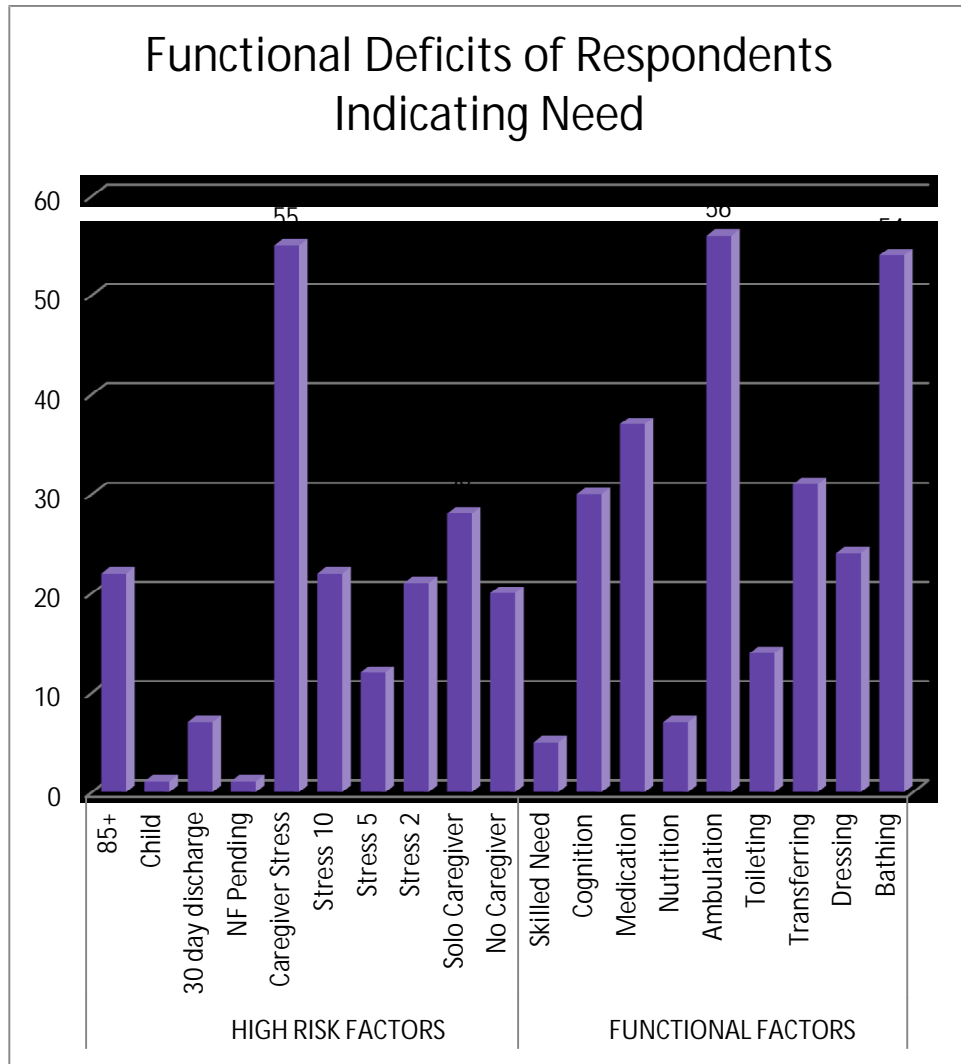


Figure 20: Analysis of the Functional Deficits and Risk Factors for Respondents Indicating a Need

For those indicating an unmet need in providing for their functional deficits, the numbers are slightly different. It can be expected that these individuals would represent a higher risk group and indeed the percentage of risk factors is higher

Risk Factors for those with a Need			
Total with high risk indicators 97%	Percentage of those with a need	Percentage of the total assessed	Number of respondents with need
Ambulation	73.7 %	43.1 %	56

<b>Bathing</b>	71.1 %	43.8 %	54
Medication	48.7 %	31.4 %	37
Transferring	40.8 %	24.8 %	31
Cognition	39.5 %	26.3 %	30
Dressing	31.6 %	21.9 %	24
Toileting	18.4 %	14.6 %	14
Nutrition	9.2 %	8.8 %	7
Skilled Need	6.6 %	4.0 %	5

Figure 21: Risk Factors for those with a need

Although Ambulation and Bathing are still the highest ranked deficit, with those who have an unmet need in a functional deficit, it is more likely to occur in ambulation rather than in bathing, unlike in the general population. Interestingly, transferring is also more likely to occur in this group over problems with cognition.

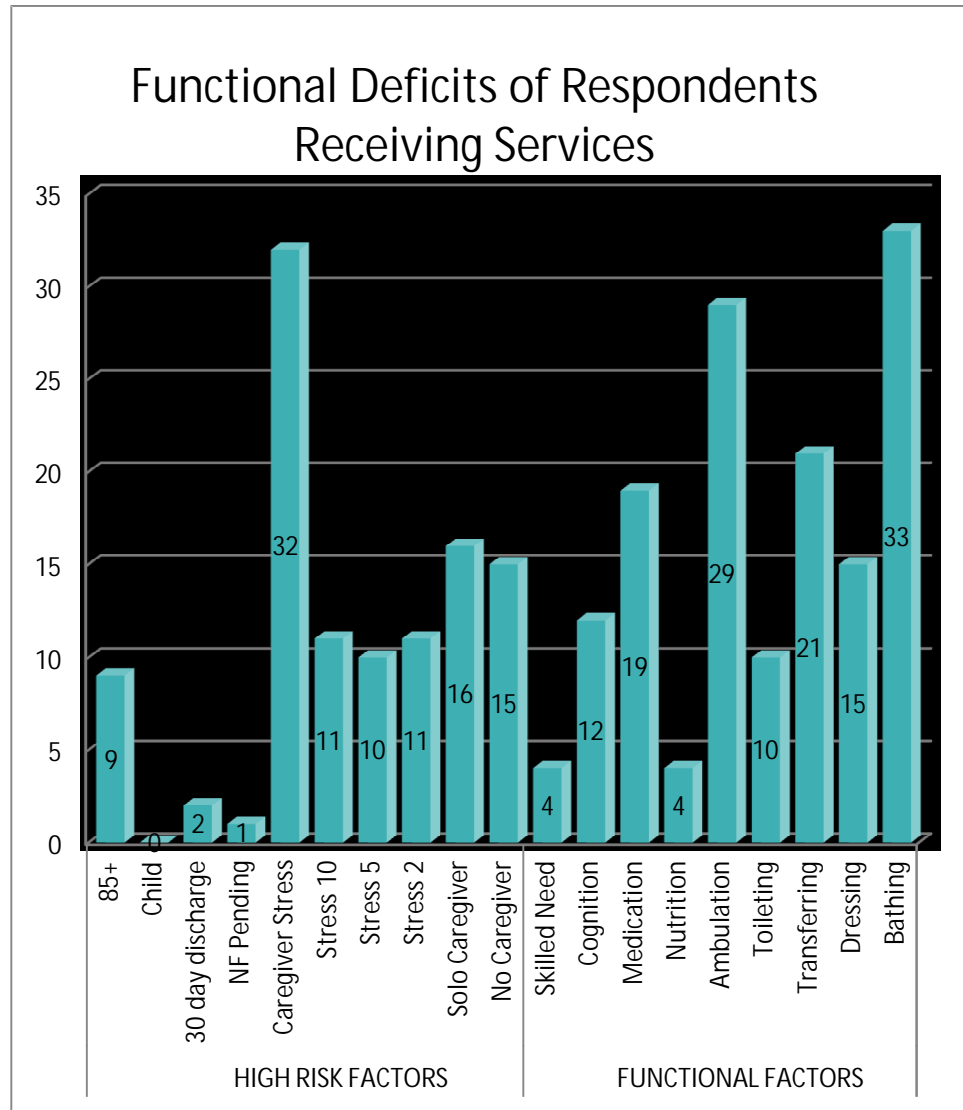


Figure 22: Analysis of the Functional Deficits and Risk Factors for Respondents Receiving Services

The functional deficits of those who ultimately received services mirror the general population. Bathing and Ambulation are by far the largest deficits for people who are experiencing difficulty in managing their Activities of Daily Living.

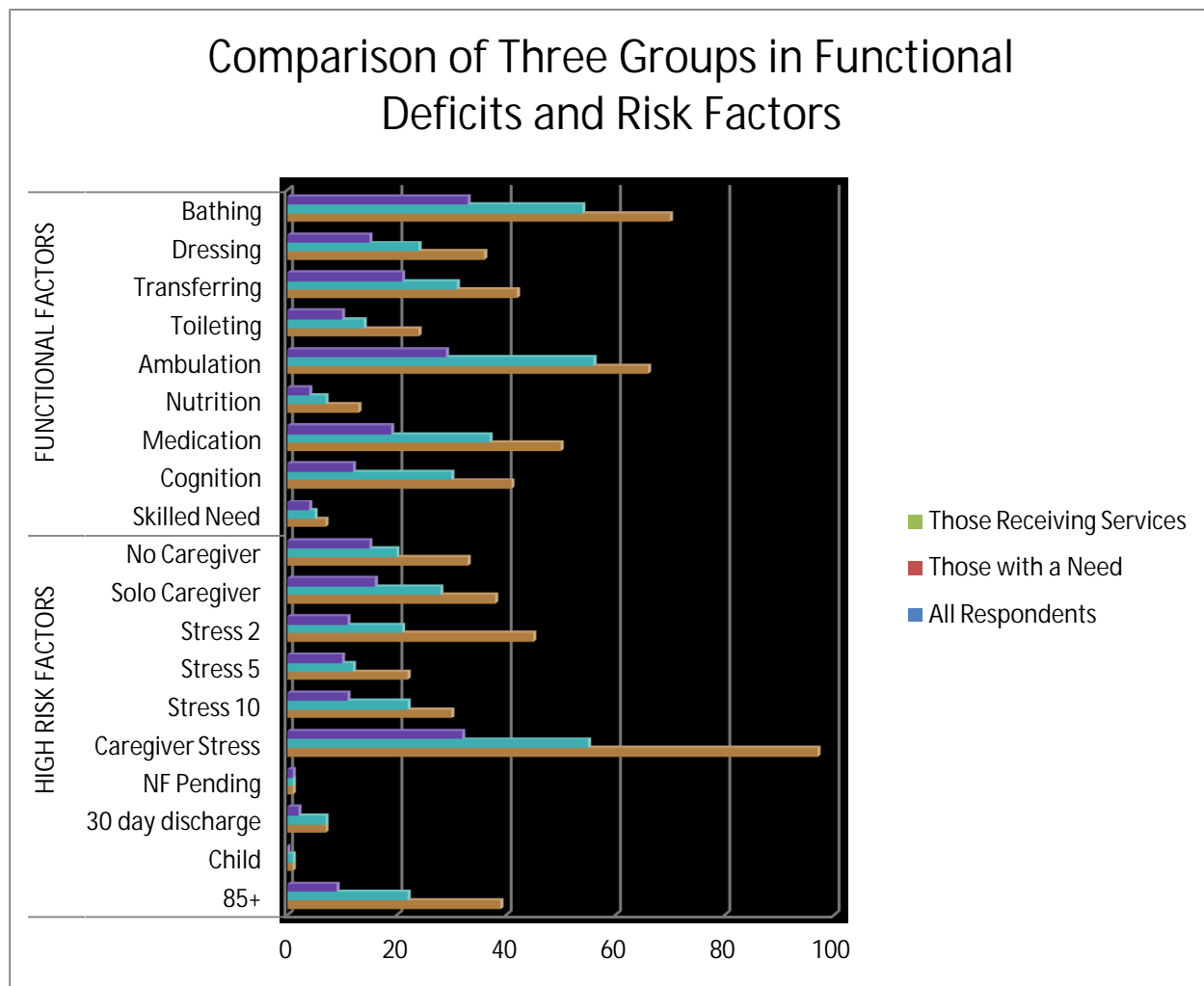


Figure 23: Comparison of the Three Groups in Functional Deficits and Risk Factors

A comparison of the three categories continues to illustrate their similarity. Those areas where we might have expected the largest population, in cognition and skilled need have not been realized. This has implications then for how we triage services.

***This information has already begun to be formalized into our plan for moving forward. We will make sure that staff are well informed on interventions both private and public, to assist people with these functional deficits. Additionally, we are beginning to plan for more case management training and resources to go into supporting caregivers.***

## Review of the Prioritization Tool from the LifeTime Resources staff

In comparison to the Eligibility Screen (EScreen), we feel that the PT is a more accurate reflection of the client's situation. We like the ability to have a more detailed look at impairment and needs that the PT offers. The PT allows three choices to describe the person's level of impairment related to an ADL where as on the EScreen there is a check for any impairment and we are counting on the CM making additional notes to explain the level of impairment.

In comparing the two tools, it is clear that the EScreen only looks at impairments while the PT looks both at impairments and need for service. It would be our recommendation that the PT impairment score would be used to determine eligibility for funded services and the need score would be used to determine the level of service provided.

We like the idea of considering short term provision of service to a client when computing need. However, we would recommend that it would not be an automatic "add-on" score but rather worked into the description of level of need.

In our testing, we could not draw direct correlations between the PT and the EScreen scores. Similarly, we could not draw a direct correlation between the PT score and the cost of our care plans.

We recommend the addition of an IADL section to the PT so that those impairments and needs can also be scored.

We recommend a Client Narrative Summary section that can be used similarly to the E-Screen "Comments" section. This would be the area that a descriptive paragraph or two sums up the client situation. If not a summary section, there could be an expectation of a summary paragraph in the case note related to the completion of the assessment tool. (This would eliminate duplication of info in the assessment and case notes)



The eligibility screen allows for scoring for persons with mental illness and also for persons with development disabilities (CHOICE only). This appears to be missing from the PT. Since Aged and Disability services have been merged together it may be necessary to include the ability to consider these elements

We found that the high risk section is more of a measure of urgency of need as opposed to be considered an eligibility category.

## ADRC

Perhaps most open to the proposed changes, were the ADRC call center staff. This group was in the position of having to hear difficult stories of need and not being able to offer much to consumers other than information and support. The wait list was an option but not a practical one in the short term. The idea of not having a wait list and being able to offer support when someone needed it was a lifeline for them. They were ravenous for information and extremely supportive of the changes we were proposing. They were anxious to move forward and frequently asked for and expressed appreciation for informational updates.

## Determination of Need

When we began to look at how we defined need, we saw reduced care plans. How we approached a redefining is noted below. All these combined led to significantly reduced care plan costs.

- What was critically needed and what was not;
- Authorizing short term services based on prognosis; and
- Authorizing specific tasks for a service as opposed to approaching services in a broader manner

The results are startling and significant:

	Average monthly cost	Annual cost of care plan
Pre- redefining	\$ 647.70	\$ 7,772.40
Post-redefining	\$ 175.66	\$ 2,107.92
Difference	\$ 472.04	\$ 5,664.48
<b>Percentage savings</b>	<b>380%</b>	

*If this amount were to be projected to the number of clients currently served in Area 2, it could represent an annual savings of as much as \$ 9,000,000.*

1642 clients as of 10/12 all funding	Monthly	Annual
Pre-redefining	1,063,523.40	\$ 12,762,280.00
Post-redefining	288,433.72	\$ 3,461,204.60
<b>Difference</b>	<b>775,089.70</b>	<b>\$ 9,301.075.40</b>

Calculated more specifically by the number of actual clients in each category, the assumptions remain accurate and cost savings is considerable.

Funding Source	Average cost	Client numbers	Annual cost	Annual cost at \$175.66 monthly
Choice Elderly	\$ 681.00	183	\$ 1,495,476	\$ 385,749
Choice Disabled	\$ 586.00	27	\$ 189,864	\$ 56,914
SSBG	\$ 293.00	100	\$ 351,600	\$ 210,792
TIH	\$ 276.00	39	\$ 129,168	\$ 82,209
A&D Waiver	\$ 681.00	1293	\$ 10,566,396	\$ 2,725,540

TOTAL			\$ 12,732,504	\$ 3,461,204
<b>Annual Cost Savings</b>				<b>\$ 9,271,300</b>

Figure 24: Average Care Plan Costs by Funding Source

### CRITICAL VERSUS NON-CRITICAL NEED

The purpose of identifying critical and non-critical needs is to find another means to address the need other than relying on state and federal funding.

A non-critical need is one that is not immediately required to insure health and safety. Without the need for immediate assistance it could be assumed that we have additional time to look for alternatives ways of meeting the need, while we are assured that the client's health and safety needs are being met.

Clients who have a non-critical need are entered on a database (Document GG) and their needs are addressed more easily and efficiently than in the past. With a database that can report on certain zip codes and need categories, the information can be used to target volunteer services, request financial support from the community and to approach service groups with concrete information. Our previous database did not allow for the manipulation of information into very specific reports.

The database developed under this grant tells us exactly what people need and the need has been verified. In the past volunteers might be sent to a home where the need was not verified but based on the information provided by the caller at the time they were entered on the wait list. Volunteers would occasionally report that the person was not in need of the volunteer support they received. This is disheartening to the volunteer and to the staff. In our new system we know that the need is real and we know the extent of the need.

As an example, we have the information available now to contact a school or church and tell them that there are 3 people in their own community who are waiting for a ramp, and solicit specific support. Additionally, grants can be written to community organizations requesting financial support for those individuals. The information is concise and Case Managers, Volunteer Services, and fund development staff are all working to get the needs met without relying on tax dollars to accomplish it.

Non-critical services are also noted on Action Plans and become part of the Case Manager's responsibility to work on with the consumer. The non-critical need is communicated to the Case Manager from the Resource Counselor during the transition process. This allows the Case Manager to begin working with the client to meet the need through the consumer's informal support systems and/or community connections. Of those clients seen by the Resource Counselors, 33% had a non-critical need and were entered in the database.

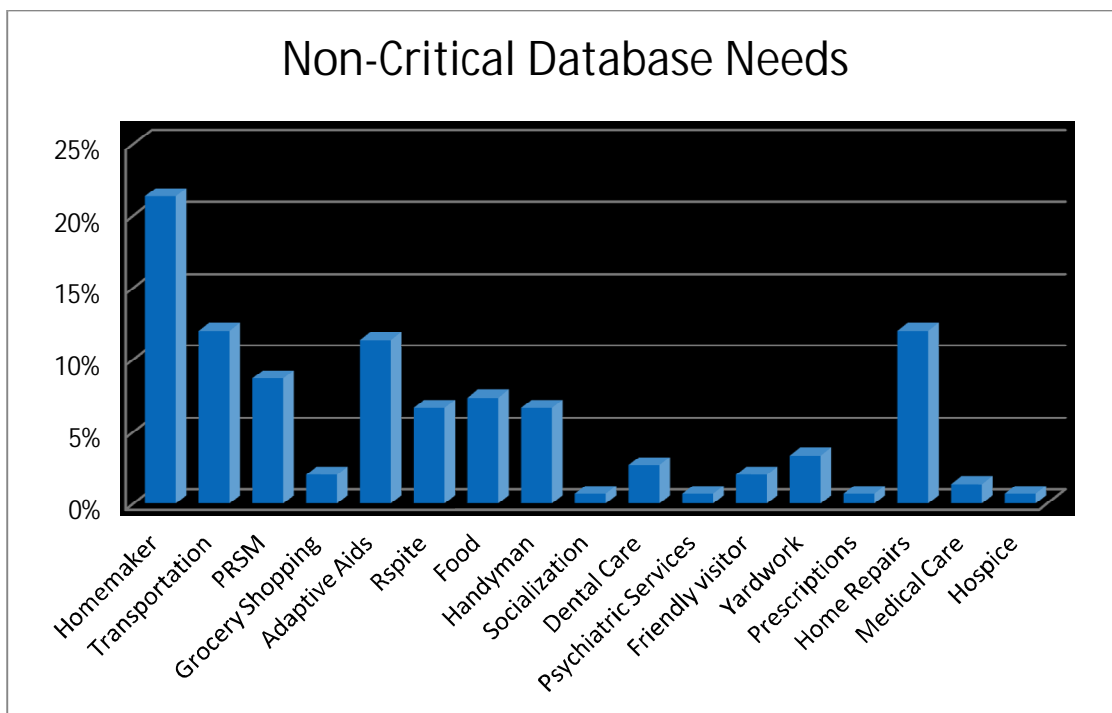


Figure 25: Non-Critical Database Needs

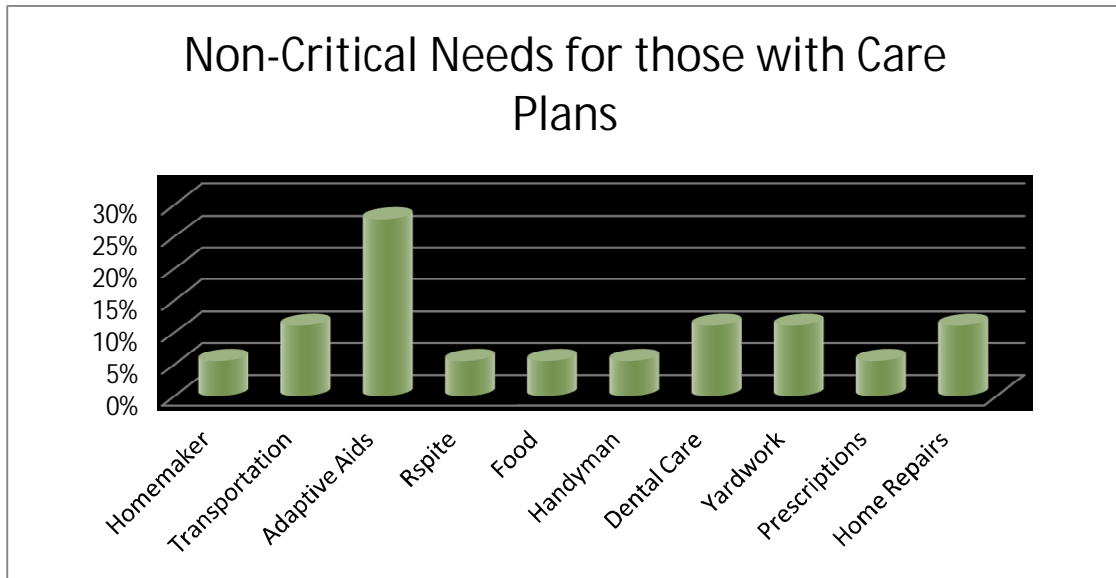


Figure 26: Non-Critical Needs for those with Care Plans

## Action Plan

The Action Plan (See: Attachment F) is a tool to assist the client in following up with information and resources provided by the Resource Counselor or ADRC staff. The Action Plan is a restatement of what was discussed and contains detailed information so that the consumer can remember all of the information that was shared. Containing all the information in one place makes access easier for the consumer and supports Person Centered Care. Of those who were seen by Resource Counselors, 36% received Action Plans.

## AUTHORIZING SERVICES

Resource Counselors having no previous Case Management experience in aging adapted well to authorizing services in a new way.

As we transitioned from a pilot and began to integrate our work into the larger case management program, we began to get inquiries from case managers who were wondering about what to do when the service plan expired. They were not comfortable with telling clients that

they may no longer need services. There were also instances where the client asked for additional services beyond what had been authorized.

Recognizing the potential for a digression from our purpose, we developed a process to help case managers make the change in a manner that would support them in their new role. We developed a team that would review all requests for additional services or extended care plans. The role of this group was to review the request, redirect if there were other avenues that had not been adequately explored by the Case Manager and then to approve or disapprove the request.

In establishing a quality control group in this way, it took the Case Manager out of the mix for making the decision. Instead they became the advocate and the relationship was maintained. The role of the Case Manager was to complete a request form (See: Attachment HH) and submit it on the client's behalf. The team would quickly review and turn around the document. The case Manager was then able to be seen only as an advocate, a messenger and a liaison between the client and the quality control group.

Case Managers were grateful not to have the role of taking a "heavy hand" with the client even though in most cases they agree that the services are no longer needed or additional services are not necessary.

We believe that it is critical to authorizing services in a new way, that Case Managers be given adequate training and support. They must fully understand what critical versus non-critical needs mean. Additionally, they must become comfortable thinking of short term services as opposed to extended care plans. They fully understand why this is reasonable and makes sense for the client.

## RESOURCE COUNSELING

Having newly trained people who had no previous training as case managers was helpful in that they had no problems adopting a way of doing things. They knew nothing but what they were trained on. Where current staff may have struggles with asking personal financial questions, the Resource Counselors did not. We invested a great deal of time in training so they would have the tools to do their job well. Current staff would require training and support in modifying case management as they know it, to a new model that really delves into the individual's personal financial information.

The following question was asked of the staff of *LifeTime Resources* staff regarding the role of the Resource Counselor.

**Question:** Does the resource counseling model work and should we recommend it for all HCBS services, including Medicaid Waiver and Medicaid?

**Answer:** Yes. It maximizes ADRC funding targeting those most in need, while providing information and support to everyone. The same model applied to Medicaid Waiver and Medicaid HCBS, would result in lower care plans costs and more people served.

The Resource Counselors were very good at notifying us when they had encountered problems in areas they were unfamiliar with. They were challenged at times to get people to allow them to make the face to face appointment and were searching for ways or things to say that might open doors more readily. We offered the following support for them.

### ***Talking Points for getting an appointment...***

- *We can help them understand what they may need and benefit from;*
- *We may be able to help them find ways to meet their needs;*
- *We're not asking for anything or selling them anything;*
- *The help is available through the Older American's Act of 1967 for anyone age 60 and over;*
- *If they refuse, we can talk to them over the phone;*
- *Can we send them some information on our programs and others that they appear to qualify for?*
- *Can we call them again in a few months to see how they're doing?*

## **LESSONS LEARNED**

- *It can be difficult to get people to agree to let you visit them in their home. (see talking points below)*
- *As much as you are able, encourage the client to have family, or trusted friends, present during your first visit. There is a lot of information shared, and it helps to have someone else hearing what is said.*
- *Often these are the decision makers, which can also speed the process along. If they not consulted earlier, clients will often wait to make a decision until they can consult with them. In this case, the information shared may not be complete or the most accurate.*
- *If they are caregivers, they may be able to help the client understand that they need help.*

## Cost Share

There were a number of challenges in developing the revised Cost Share. Although we tried to mirror Medicaid as best as we could having a uniform system with multiple counties presented a problem. For instance, in working through deductions the housing deduction allowances we found varied by county. We also tried to look at the current deductions allowed in the CHOICE program and determine whether they were a duplication and how they measured against Medicaid's deduction allowances.

We did not address a threshold for asset eligibility as is the case with the CHOICE program. Our approach was that anyone could be eligible but that they would have a cost share.

The Resource Counselors struggled initially with having this conversation with resistant clients. We all believed that the cost share was fairly determined but struggled with seeing someone who needed the help but declined due to cost share. Although there were not a considerable number of these individuals, it was a struggle for them to know how best to handle that conversation. Some talking points were developed and we had a discussion regarding the fact that although this change may seem an unsympathetic departure from our current practices, it is nothing less than would be required of any individual seeking admittance to a nursing home. Ultimately we intended to capture people in our safety net and hoped that they would realize that any discount on services would be better than full payment. Further we hoped that they would



call us when they realized that what we were offering was more equitable then and more desirable than nursing home placement, which would be 100% cost share.

***Talking Points for discussing cost share...***

- *If you don't spend resources on preventing decline, decline will happen faster. If that results in a nursing home stay you will pay 100% of the bill until you have nothing left.*
- *The cost of a nursing home is well over 50,000. A year. If you use that to provide for your care at home, you can stay at home longer.*
- *The average annual cost for home care services is 7,200. You would only pay a portion of that not 100%.*
- *If you have people who are able and willing to help out the average cost of home care can be reduced even further. We can help you put together that plan, so that you're maximizing what you have.*
- *Medicaid requires that you spend all your savings. Using your own resources helps to keep you from going on Medicaid sooner than you need to.*
- *Cost share is equitable, everyone's contribution is calculated the same way.*
- *If everyone contributes what they can, we can serve more people.*
- *Cost share can also be beneficial in helping consumers and their families coordinate care. We authorize only those services that are essential, we complete all quality checks, we pay all the monthly care bills and send one invoice to the client or their designated person.*

We found that the discussion of cost share can sometimes drive people away, and we realized the importance of approaching slowly and with preparation. Once the Resource Counselors had prepared responses to the clients concerns they could respond more confidently. Ultimately we hoped that the client would reconsider and reach out to us again.

We found that it was not uncommon to have family appear when we began discussing the possibility of the client contributing financially. Family at times would suddenly agree to provide the care themselves to protect the client's resources. This was a good reason to take the additional time to have all interested parties in on the initial discussion. This is also why we found the follow up call to be important. It was important to check back to make sure that the family followed through on their promise to assist the individual with their care.

Listed below are the comments from the *LifeTime Resources* staff regarding the cost share component.

**Question:** The goal is to assist people in maximizing their resources and not impoverish. Does the CLP Cost Share model achieve that goal and should we recommend it for CHOICE, SSBG and OAA where allowed?

**Answer:** Yes

- We showed that many can and will cost share; a small percent refuse and some of those return later.
- It maximizes client resources, both income and assets; targets government funding to those most in need.
- Allows adequate resources to live at home by allowing deductions for both medical and living expenses for housing, utilities and food (fair, but no luxuries like cable, etc).
- Allows an asset deduction for homeowners for taxes, repairs, etc.
- Cost share doesn't start until \$10999 income (after deductions) = \$916.58 vs. \$698 for MA spend down threshold, which impoverishes.

**Question:** What changes would you recommend?

**Answer:**

- We would recommend using the 100% poverty level as the starting point (\$930.83 for a single person household at present) and that this be updated annually. Seems reasonable that no one should have to live below poverty simply because they need government assistance.
- There is no spousal impoverishment protection. We recommend using the Medicaid spousal impoverishment model for the Asset portion of the cost share only

A concern regarding the implementation of the cost share proposal across programs is that it is cumbersome to obtain the required information and sometimes the need for service is time sensitive. Similarly, sometimes assets are not liquid and steps would be needed to obtain those funds to pay for service. This isn't insurmountable, but ADRCs would have to put systems in place to assure needs are met expeditiously.

## Verifying Resources

Initially our challenge was in how to verify resources without taking documentation from the home and yet maintaining a record of the verification. We opted to purchase I-Pads which could be used to photograph documents without actually removing them. We also used the I-

Pads to install forms that the client could electronically sign, making it more consumer-friendly and easier than carrying a large number of documents.

It was at times challenging and time consuming to verify resources. We did not have the complete access to asset information that the Medicaid system has. If in the future, it is determined that asset verification should be completed by the ADRCs, it would be extremely helpful if collaboration could be arranged through the Medicaid offices so that an accurate and timely assessment can be completed.

***Talking Points for verifying resources...***

- *If at some point you are looking into a nursing home for care, they will expect you to spend all your own resources until they are all gone, and then apply for Medicaid. Medicaid will require verification of this and much more.*
- *Sharing this information helps to understand what if any, assistance you may qualify for.*
- *Even if you choose not to share this information, we may be able to offer you information that you would find useful.*

Consumers would often have a difficult time producing documents, however we incorporated this into the Resource Counselors role which then made it easier for clients when they actually needed to apply for Medicaid.

Consumers appeared no more concerned with sharing this information than they did with cost share. One of our concerns was that the person would not feel comfortable sharing this level of information. Indeed we were questioned about it on occasion but were always able to explain why we were doing this and how it would help the client.

## PERSON CENTERED CARE

What we had not anticipated were the negative affiliations staff had developed around the phrase “person-centered planning” which harkened back to their experiences in the disability

network. For some they automatically assumed that this would mean working weekends and nights, being on call and being available 24/7 if needed. Despite our efforts to clarify, there were some who threw up road blocks immediately based on just the reference to person-centered.

There were others who embraced this change however and for them the process was meaningful and more in tune with their social work skills rather than functioning as a broker of services. Some of their comments are noted below:

*I have a client who lived in a South Bend senior housing complex but her family is all in Michigan City. She very much wanted to move closer to the family but couldn't get the courage to take the step. We broke everything down into small steps and got her daughter involved. By breaking it down and figuring out what order things needed to be done, it made the project easier for her. She could work on one thing at a time. I made the first call for her and then she and her daughter took over and within 3 months she had found an apartment and got moved in. Since she is closer to family – her daughter goes with her to the doctor so we have decreased the ATTC hours.*

*I worked with a young TBI client who set a goal to find a job and get an apartment. Obviously this is a long term goal. We started small and decided maybe volunteering would be a good first step and build a resume since he has never worked. We made lists and researched opportunities. His Mom helped and he ended up going back to his elementary school working with 1<sup>st</sup> and 2<sup>nd</sup> graders . He felt a sense of achievement and those kids got a firsthand look at someone with disabilities. Since the school closed at the end of the year he had to find a new opportunity. He starts Monday as a volunteer at the nutrition site in LaPorte.*

*I have an 89 year client who suffered a stroke and had left-side weakness. She lives with her son. She really wanted to walk again. We set that as her goal. The doctor wouldn't order PT but said he saw no reason that Jim (the son ) couldn't work with her if he wanted to. So they started slowly. Just a few steps each night. When I went to visit her today she shared a secret with me. She can now walk with the walker, standby assist and a gait belt from her chair to the bathroom. She has gotten strong enough that the HHA now feels safe walking with her. No one but her son, the HHA and me knows what she can do . She is going to surprise the rest of her family on Christmas morning when everyone comes. She hopes to be able to walk the length of the house by then. There were tears in her eyes, the HHA's eyes and mine when she told me. She got the best gift of all – the ability to control one little part of her life. This is what the job is all about!*

*Jeff is a 41 year old male who has paralysis from the chest down due to a car accident. Jeff's primary caregiver is his mother/Pat who had a decline in health and was not able to stand on her feet for long periods of time due a medical condition. At this point Jeff was bed bound, taking sponge baths and Mother was doing everything for Jeff (arranging apts, making phone calls, getting groceries, taking him to his Doctors apts, meal prep, homemaker tasks, Rx reminders, IV therapy, incontinency/per-care, dressing assistance, back up caregiver, and wound care). Jeff informed me at his home appointment he thought he would need to go to a Nursing Facility and he did not want to. We spent two hours brainstorming ideas of where Jeff could live, who he could live with, and who else could care for Jeff. In the end, I presented him with all the choices Jeff had. I told Jeff to call*

*me when he made a decision. I challenged Jeff to take his care into his own hands and be more independent. I told him he had the option to stay at his home and be responsible for more of his own care. I told him if he wanted to he could stay home and out a NF but he would have to take on more of his care and it would require work on his part. Several weeks later I got a call from Jeff; he had gone out and gotten the voice activated cell phone I had told him about. Jeff wanted to take control of his own care. Jeff wanted to meet with his Home Health Care provider and talk to them about increasing his hours and changing his care plan. I arranged a meeting with the RN supervisor. We discussed options asked for increase of MAPA hours so that HOHE can take him to his Doctor's appoints and take him to the grocery store. Jeff is now getting out of his bed every day and getting into his wheelchair. Jeff gets out into the community weekly and goes to his appointments independently from his mother with his HOHE. Jeff taking a full bath in his fully remodeled ADA bathroom which he had not used in years. Jeff arranges his own appoints and makes all his phone calls independently. Jeff's mother feels she can continue to be the primary caregiver as Jeff has taken over enough of his care to get her off her feet and provide her with respite time to allow her to continue to provide him with the other care he cannot provide for himself; meal prep, homemaker, Rx administration, IV therapy, incontinency/peri-care, dressing assistance, oral care, colostomy care, back-up if aide is no show, and wound care (at times). Jeff is happy with his current situation and more independent that he has been since his accident which caused his paralysis.*

## REDUCING CASE LOADS

The staff was concerned about the amount of time that would be required of them to shift their role into person centered care model. Based on our initial experiences we expected that initial contact would be time intensive but would actually lessen over time as the client takes more control and the Case Manager becomes more comfortable in their role.

In order to get full compliance however, the administrative staff agreed to reduce case weights from 150 per staff to 100. This represented a significant compromise on the administrations part and necessitated the immediate hiring of eight new Case Managers to handle the increased responsibilities.

This decision however turned out to be a good compromise. In giving the Case Managers time to begin person centered care, we received much greater participation and a new sense of ownership of the process.

## STAFF SURVEY

The staff were surveyed (Forms Attachment II) on how they felt about this change in their role. The results of the survey (Research Attachment JJ) show interesting results.

In the three sections of questions we directed them to specific areas:

**Section one:** the case manager's perception of how the process impacts the client

I believe that the client is more empowered to make changes

I believe that the clients have become more independent

I feel the client values this process

**Section two:** how the case manager views their role and the impact on them

As a case manager I see areas where clients can make change

I believe case managers can be a strong facilitator of change

I see this as a true case management function

I enjoy working more closely with the client

**Section Three:** how the case manager views the administrations role

I feel adequately trained

I feel I understand what we are trying to accomplish

I believe that the current service delivery system requires change

	<b>Disag ree</b>	<b>Neut ral</b>	<b>Ag ree</b>
I believe that the client is more empowered to make changes	7.1%	17.9%	75.0%
I believe that the clients have become more independent	10.7%	42.9%	46.4%
I feel the client values this process	29.6%	22.2%	48.1%
I have seen a reduction in the need for formal supports	29.6%	44.4%	25.9%
As a case manager I see areas where clients can make change	0.0%	7.1%	92.9%
I believe case managers can be a strong facilitator of change	7.1%	0.0%	92.9%
I see this as a true case management function	7.7%	7.7%	84.6%
I enjoy working more closely with the client	0.0%	14.8%	85.2%
I feel adequately trained	29.6%	11.1%	59.3%
I feel I understand what we are trying to accomplish	7.4%	0.0%	92.6%

Figure 27: Staff Survey Results for Person Centered Care

The responses from the staff show the highest agreement in areas that address their role. They appear to feel confident that they see the need for change and that they are the one's qualified to implement the change.

They were less apt to agree on its positive impact on both the client's independence and leading to reduced services. This is understandable given that goal setting is one leg of the pillar that leads to reduced care plan costs. In and of itself it will likely have a limited impact.

The negative view was more likely to impact training, believing that the client values the process and in seeing a reduction in the need for services.

It is interesting to note that the case manager sees where clients can make change (93%), believes clients are more empowered to make change (75%) and yet 30% do not believe the client values the process. This may speak to the need for more extensive training to help the case manager explain and guide the client through the process.

In summary, it was apparent that some of the staff wanted more training and were unhappy with the database. As a result of the survey, visits were made to all the county offices to clarify some of the misunderstandings. For instance, the database was intended as a tool and many had developed their own more effective way of managing timelines for goals.

Broken down by sections, the summary below indicates the overall responses were positive (Agree).

	<b>Disagree</b>	<b>Neutral</b>	<b>Agree</b>
Positive Client impact (questions 1-4)	2%	31.8%	49.1%
Positive CM impact (questions 5-8)	10.6%	4.7%	84.6
Positive Implementation (questions 6-11)	14.8%	13.3%	72.8
<b>TOTAL</b>	14.2%	14.7%	71.1%

## 1. WHAT DO YOU BELIEVE HAS THE MOST VALUE?

- Listening for needs and knowing resources of the community.
- Giving power and independence back to the client.
- Engaging the clients – allowing them to be the drivers of their care.
- This program has allowed a relationship to build between myself and clients. They feel more comfortable sharing information with me.
- Focusing on person centered planning in a holistic manner that is client driven. We need to practice active listening and focus on the person not just the service needs.
- Seeing the client get excited about positive changes. It's a sense of accomplishment for the client primarily and the case manager secondarily.
- For clients who are optimistic about the goal-setting process, I believe they value being able to see their accomplishments or change in their lives. They value working closely with others who are available to listen without judgment.

Clearly the Case Managers see the value in having a closer relationship with the client which also helps to establish their role as a facilitator and a trusted resource. They also value that it brings something to the client that was missing previously. It appears that they understand their role in the process and have identified the ability to practice active listening as a need for them as well as remaining focused on the individual.

## 2. WHAT DO YOU BELIEVE HAS THE LEAST VALUE?

- The paperwork that evaluates the background of the client – too personal. The data base – takes up too much time. Hard to use.
- How time consuming this process is when compiled with all the other tasks associated with client care (quarterlies, annuals and crises situations)



- Many clients are not willing to participate due to their age, pain, or depression,. If we're talking about centering care around the person, we have to also recognize that not everyone will agree to participate.
- I feel as case managers we were already completing PCP with the client.

What appears to have the least value to the Case Managers was additional paperwork responsibilities and having to deal with a database that contains too much repetition of work. The identification of resistant clients was a problem initially. Many Case Managers later reported being able to work around that in time and were also reminded that it was agreed that the process would not be appropriate for everyone.

### 3. IF YOU FEEL ADDITIONAL TRAINING IS NEEDED, WHAT WOULD IT BE?

- Completing paperwork. Measuring goals.
- Appropriate goals, desired outcomes, how to write an effective goal.
- The difference between case management duties and goals.
- CLP, how to present with a positive spin, finances.
- Teaching how to identify goals and how to break them down.
- More ways to motivate clients.

Additional training was provided in goal setting with clients, as a result of this survey. Staff were also given talking points to help them present the program in a new way. They had requested a speaker on motivational interviewing but it was not approved under this grant and will need to be provided at a later date, if possible. We are planning now to train all the staff so that they can fully implement person centered care, not just in the area of goal development but in the authorizing of services as well.

## FOLLOW-UP

Initial follow up was completed on those who were contacted for the CLP grant. We broke the calls down to those who had only received brief contact and those who had a face to face assessment. The results below show that close to 100% of those we had an interaction with, were satisfied.

<b>CLIENT SATISFACTION SURVEY RESULTS</b>	<b>Face to face contacts</b>	<b>Phone contacts</b>
Were they polite and courteous?	100%	100%
Did you find them helpful? (offering direction or suggestions)	100%	100%
Were you able to follow up on the information they gave you?	96%	100%
Yes - did you get what you needed?	100%	100%
Would you call us again if your needs changed?	100%	100%
Would you recommend us to a friend?	100%	100%
May we call you again in 6 months to see how you are?	97.6%	100%

Figure 28: Client Satisfaction Survey Results

## HOME CARE MANAGER

For the Case Manager, the need to know what is going on while being somewhat protected is essential. No process will succeed if they are not an integral part of it primarily because their input is critical.

From the onset, the staff were brought into the discussion of what we were doing and what we were trying to accomplish. They unanimously agreed that they had clients that they

believed did not still need assistance, or that assistance was being provided over and above what was necessary. They did not understand how we would make the change but fully supported the ideas brought forward.

What we found was that it would create such a culture change that staff, although they agreed with the need for it, occasionally worked against us. The following is an actual event that occurred and illustrates both the level of resistance that an organization can encounter and the culture shift that needs to occur at the higher level when change issues travel beyond the doors of the ADRC:

***The client was on the wait list for services. We met with the client and found that the individual had all their needs met through their informal supports. We checked with the caregivers and were assured that they did not want nor need any help right now. We gave them information on how to contact us and assured them that if anything changed, they would be served immediately. The client voluntarily withdrew from the wait list.***

***When the Case Manager found out she argued with the staff that the family did need help. We restated what the family had communicated to us and assured her that if that changed we would serve them immediately.***

***The Case Manager contacted the family and encouraged them to appeal. The family appealed and we explained how we had come to this point. Based only on the fact that the person had the requisite number of checks to determine eligibility, the decision was overturned by the State staff.***

***When we restated our reasoning, the State staff agreed that an error had occurred on their part but did not want to overturn their appeal decision. The Case Manager won and we all lost momentum.***

This example illustrates the need for a watchful and diligent eye toward the inclination for staff and even processes to resurface with old paradigms. When these are encountered they must be dealt with quickly through communication, education and policy development – all of which are essential in keeping it from happening again.

In the example above, it was apparent that the Case Manager felt they were being good advocates for the client. In response to this, we developed a policy on advocacy (Document KK).

Our intent in choosing policy as an intervention was that we needed to be able to use it as a disciplinary tool if needed. Violation of a policy is a more severe infraction than not following a procedure. It was essential given that this premise was key to everything else, that we handle it in this manner. The policy was provided to the staff at a meeting when it was reviewed with the staff. The group was also informed that an infraction was a violation of a policy and would be handled accordingly. They were also encouraged to bring their concerns forward in a productive and positive way.

### The Waiting List

When the CLP grant began, we told the staff that in two years we would have no waiting list, and began documenting the waiting list weekly (See: Figure 29)

As we contacted and met with clients using the prioritization tool and our new approach to defining need, we began at the bottom of our wait list. Our thought was that those who had been waiting longest should be offered help first.

When we had hired our third Resource Counselor, we could diversify our approach, anxious to know if results would be the same with a more recent contact. We then started to target those who were at the top of the list and moved backward. Our final step was in targeting folks who were actively seeking help from the ADRC. Although the results were virtually the same in what we saw as needed services and functional deficits, there were some notable differences in the accuracy of the need based on time.

The waiting list did decline considerably. As we helped people work through their needs, helped to identify resources and defined critical versus no-critical, we found that people did not always need funded help.

*In one example a lady said that she really only needed transportation services. She expressed concern about having to ask her son and daughter and that she really hated to ask them for their help every time she required transportation to the grocery or to a doctor appointment. The Resource Counselor helped her work out a schedule for rides and talked to the son and daughter and got everyone to agree to what they would do. She no longer had to call and ask them, there were regularly scheduled trips. The son and daughter were helped by knowing the days when their help would be needed and the mother no longer had to constantly bother her family asking for help. This is an example of how services can be coordinated among informal supports and state and federal dollars reserved for those who have no other options.* Along with consistent targeting of Aged and Disabled Waiver clients, our waiting list has been reduced from 1645 when we began in October of 2011 to 911 after little more than one year. This represents a reduction of 181% in one year.

It should be noted that until we began to implement this new need based assessment process, our wait list numbers were continuing to climb. In fact in three months previous to this our wait had grown by 441 people.

### THE IMPORTANCE OF COMMUNICATION

Those on the front lines understood why we were seeking to make the changes we were and they welcomed being a part of addressing the issue and making the changes.

There were a number of ways that we attempted to maximize the effectiveness of communication to the staff. A monthly newsletter provided to all staff on programs was expanded to include a section on the CLP grant progress. Additionally, questions were gathered as they arose and compiled into an FAQ that was released to all staff twice (See Attachment LL).

Periodic trainings were held, where progress reports were given, challenges were explained and the staff was given an overview of their role and the timeline. We also regularly addressed the one projection made in the first meeting, “In two years, we will have no waiting list”. The waiting list did continue to come down in number as we addressed the needs of consumers in new ways.

For the Case Manager, the need to know what is going on while being somewhat protected is essential. No process will succeed if they are not an integral part of it primarily because their input is critical.

### CULTURE CHANGE

Making the change that *LifeTime Resources* began many years ago took a tremendous vision and a real commitment on the part of the leadership and staff of that organization.

*LifeTime Resources* is a smaller rural Area Agency on Aging. Area 2 Agency on Aging is the third largest ADRC in the State of Indiana. The real difference between a smaller urban and larger rural organization is not its size however, it is the culture. If that is not addressed, there will be no real change.

When making a change in a larger urban organization, the key components of what the organization wants to accomplish may be the same. It was our intent to prove that the vision can be the same, but the navigation must be different. The “waters” that the organization must navigate carefully is actually the culture. Each organization has its own culture that will either assist or challenge change. The task before the organization is how to know enough about the culture of their organization to make the change.

Probably too often, leadership believes they understand the culture of their organization only to find that they don’t or at least they don’t fully understand it. When this happens, any

change is less likely to be successful. When change is least likely to happen is when it challenges or threatens the culture.

Change may be successful if it doesn't threaten the current culture, or if the time is given to recognize the culture and plan the change within the context of that environment. Leadership's first job must be to define what the culture is and tailor the message accordingly.

In our experience, we knew we had staff who were proud of what they do and who truly wanted to serve the client. The changes we were proposing were not a challenge to that. But we also have a smaller older culture that is more comfortable in maintaining status quo. What that meant was that we had to appeal to the larger group who shared our values and minimize the impact of those who were motivated to maintain the old way of doing things.

In our first meeting with the staff to introduce this change, we made sure it was with all staff. They had to all hear the same message at the same time. Their concerns had to be captured. They had to understand not only what we were doing but what it would take. They also had to see the image, or vision that we were steering the ship toward. We also assured them that they would be part of the process, that we would do our best to communicate well. We also assured them that we would occasionally fail but that we would remain committed to getting back up and moving forward again.

We began in that first meeting by telling them where we were going. We made a simple statement, "In two years we will have no waiting list". That appealed to the group who were a committed and engaged staff. We then set out the plan for how we would make changes. Broadly at first because we were not quite sure how we would accomplish it. As time progressed and information became clearer we would occasionally bring them together again for updates. We

would always begin with a restatement of the vision. “You remember when I told you we would have no wait list in two years, well here’s where we’re at now”.

They were advocates immediately and at times had to be restrained from moving too quickly before all the preparation was complete. We appealed to their value system, and that is the backbone of our organization’s culture, and likely to be the same for most other ADRCs.

There were and still are, pockets of individuals who are threatened by agents of change, and the road has been a difficult one only because we have had to navigate around those who would support the status quo. It has also been difficult in that we had to create new processes that would continue to support the change. But we have turned the corner and the impact of the change is already apparent.

## THE CASE MANAGER’S ROLE

We believe that it is critical to authorizing services in a new way, that Case Managers more than any other, be given adequate training and support. They must fully understand what critical versus non-critical needs mean. Additionally they must become comfortable thinking of short term services as opposed to extended care plans. They fully understand why this is reasonable and makes sense for the client. The culture however has not been one of seeing opportunities for improvement but rather a steady progression of decline. Key to making this change effective is the firm understanding and ability to determine critical from non-critical service need and person centered care.

The successful implementation of the elements of this grant will likely require a change in how case managers view their role. Their responsibilities have become more administrative and less in the role of facilitator. They are supportive of this change but would benefit from ongoing support and direction in making those changes.



It will also benefit from a change in how the State views their role. At this time we occasionally receive questioned or rejected CCB's based on the number of case management hours being too high. In this new role, the culture would do better to encourage the relationship and person centered care model in case management.

Taking on this new model is a challenge in that the case manager often sees their role as one that gives not one that takes away. It will require support of the case manager and diligence on the part of administration to be watching and preparing for the old culture of giving people what they qualify for and not what they need. This is not an act of resistance on the Case Manager's part, but one of education and the need for a reiteration of the mission of person centered care.

## TALKING POINTS

We have found that anytime talking points could be developed and shared with the staff it made it easier for them to transition. Often although they understand the goal they struggle with how to address the client differently and talk through the changes we're implementing. It would help them to understand how the culture has changed and express that to others.

## LEADERSHIP

In order to successfully implement much of what was accomplished through this grant, the leadership must be committed, fully committed, and involved. There were times when the administration had to be involved to make decisions that would guide the entire process and the staff needed to see that leadership would respond in a manner that continued to support their work. One digression from the vision would be all that it would take to have the staff think that it was only "the program of the month" and not real and lasting change.

The leadership also has to be vigilant in providing support to the staff by providing the on-going vision and watching for any digression from it. Change is difficult and nothing would undermine our efforts more than the sense that we were not fully committed.

Investing in training tells the staff that you support their efforts and want them to be successful. It should be provided as needed and the staff should be constantly monitored to see what their needs are, and that they are being met.

The door should always be open to any staff to come forward with questions and concerns.

## COMMUNITY LIVING GRANT FINAL RECOMMENDATIONS

### RECOMMENDATION: MOVE TO A NEED-BASED MODEL

- New approach based on need not eligibility
- Adopt the prioritization tool and eliminate the eligibility screen with some modification
- Support a critical and non-critical need identification
- Support face to face ADRC options counseling prior to the wait list

### **BARRIERS:**

Moving from an e-screen format to a prioritization tool approach will require a thorough understanding of needs based assessment, extensive training of the ADRC's and diligent attention on the part of leadership to insure that the new tool is being used as intended.

Establishing benchmarks and monitoring tools will be necessary.

### **OPPORTUNITIES:**

By supporting a case management shift from eligibility determination to need determination, the state of Indiana would see a reduced amount of authorized services. Informal supports are more likely to be supplanted with paid services.

As has been shown in our research, the cost savings to Indiana could be substantial with a change in how services are authorized. A change to need based care could considerably reduce or even eliminate waiting lists. The change is best accomplished through a three pronged approach.

- By supporting the differentiation of a critical versus non-critical need, the ADRC is encouraged to meet the non-critical need using community supports and informal resources.
- Aging services nationally, has adopted a culture of long term services when short term care may be appropriate. The culture then makes it challenging to reduce services when need is reduced.

- Authorizing of only essential components of services is another area where savings could be realized. Encouraging a culture where we provide for only what the client is unable to do for themselves saves money and empowers the client. In a practical way what people continue to do for themselves keeps them physically stronger and promotes health and continued independence.

In providing face to face options counseling, relationships will be established that will lead to a greater likelihood for people re-contacting the ADRC when they need assistance. Additionally and most importantly, the individual will be accurately assessed for their needs in their current environment. Their needs may be able to be met immediately through alternate resources rather than being offered a place on a waiting list.

The ability to accurately document the needs and resources within the community and then use that information to promote community support is essential to building a comprehensive network that does not solely rely on state and federal funding. ADRC's should be encouraged to use the resources within the ADRC to build their informal support network. The strength of this network is helpful in meeting "non-critical" needs.

#### RECOMMENDATION: CHANGE COST SHARE

- Change deductions
- Include assets
- Be more aggressive in encouraging use of individual resources
- Reduce the base eligibility for CHOICE services
- Reduce inequities in funding sources
- Slow the progression to Medicaid

#### **BARRIERS:**

Training is essential to transitioning to a verification rather than a verbal declaration. Changes in income, asset and deduction calculations may be a challenge for existing case managers.

Making changes to the CHOICE program, Title III, Medicaid, and SSBG would require a formal process that would include changes in federal applications and legislation.

### **OPPORTUNITIES:**

Changing the calculation and determination of what is included in the determination of assets and deductions would be more consistent with Medicaid eligibility and therefore more equitable. We not only verified resources but made the asset and deductions mirror Medicaid as much as possible as a means to equalizing the determination as much as possible.

In its current format, a CHOICE client may maintain \$500,000. in assets but have little income and then little cost share. Conversely, an individual with a high income but little or no assets may pay full cost share. This system could be equalized by including both assets and income in the determination of an individual's ability to contribute to the cost of their care.

Raising the cost share percentage is recommended and would likely be supported by the entire ADRC network. Additionally, we believe we have shown through this grant that people are not deterred due to increased cost share expectations.

There are considerable inequities between funding sources in our current system. By bringing the funding sources together as much as possible, Indiana would provide a more equitable, reasonable and less confusing system.

Verifying income and assets was a component of this grant. In doing so we encountered no unusual difficulty in getting information from the clients nor in making their records available. With the addition of verification of assets that mirror Medicaid's, the system is more

equitable across funding sources and the determination of eligibility is much more likely to be accurate.

#### RECOMMENDATION: PROMOTE PERSON CENTERED CARE

- New approach for Case Management that doesn't rely exclusively on funding
- Encourage creative problem solving in resource development
- Encourage care facilitation rather than brokering services
- Engage health education models in case management practices
- Case management fostering empowerment

#### OPPORTUNITIES:

We have shown through this grant that by focusing on need as opposed to eligibility it opens additional opportunities to rethink old processes. For instance, it was much easier for the staff to understand the concept of short term care plans and the need to look at what a person needs rather than offering them the “full menu” for which they qualify. This results in considerable savings as we have demonstrated.

Encouraging case managers to work on establishing goals related to improving the health and safety of the individuals is empowering and actually results in better mental and physical health.

Much research has been done on the connection between empowerment, and improved mental and physical health. We know that depression is not only common among the elderly but when it occurs, it impacts many other health related areas of a person's life. Using goal setting as a means to help an individual improve their situation, empowering them to make additional changes and helping them lead healthier lives would be an asset to Indiana and provide for a truly person centered approach to care.

*“Encouraging patients to take an active role in their therapy has the potential to improve outcomes in the treatment of chronic diseases in which traditional care is often insufficient. Furthermore, for particularly burdensome behavioral health-related conditions, such as*

*depression, patient empowerment interventions may provide additional advantages over traditional “hands-off ” care.”“*

*Collaborative Care and Motivational Interviewing: Improving Depression Outcomes Through Patient Empowerment Interventions - Page 2* Bill Anderson, PhD, Volume 13: S103-S108 November 2007 Number 4 Sup

Continuing to support, coordinate, and develop Case Management and healthy aging programs would be a benefit to Indiana by providing consumers with access to opportunities to learn about chronic disease management and various other health improvement programming. Promotion of maintenance and improvement of health outcomes will reduce the reliance on supportive services.

## PARTICIPANT DIRECTED CARE

Lastly, Indiana’s Division of Aging sought a more responsible Participant Directed Care program that would incorporate training on all levels, enhanced quality controls and build a mentoring component for those consumers who were in need of assistance with establishing and maintaining quality service.

Scripps completed a Quality Management plan for The A2AA (See Attachment MM) that helped in guiding our effort moving forward.

As a part of the project we developed manuals for employers (See Attachment NN) for employees (See Attachment OO) and case managers (See Attachment PP).

Area 2 also developed a mentoring component to the program for participants and their employers. We have a number of employees and employers who have volunteered to be mentors but no individual has requested a mentor yet.

Consumers of Participant Directed Services who have had any adverse experience are encouraged to report it to their Case Manager. All consumers are provided a form for formally documenting the problem and bringing it to the Case Managers attention. (See: Attachment QQ)

Quality Assurance was also developed to further support on-going stability in the program. Processes were implemented that are intended to insure that the program is a viable option for the consumer. A Case Management Team Leader must now go with the Case Manager to meet the consumer and interview them for appropriateness. Additionally, if the Case Manager believes that it is not a good fit, they may defer a final decision to a Review Board (See: Attachment RR). The purpose of the review board is to ensure that the client is evaluated for appropriateness fairly. It will also assist those Case Managers who need to maintain a relationship with the client and therefore need another person or entity to make the determination.